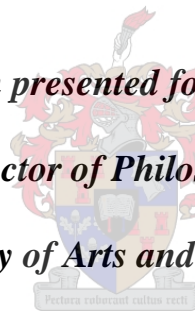


LISTENING IN HIV COUNSELLING AND TESTING: HEARER SIGNALS IN RURAL PATIENT- COUNSELLOR HIV CONSULTATION

By

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DECLARATION

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ABSTRACT

HIV/AIDS has been a major public health concern in South Africa since the late 1980s. By 2014 approximately 6.8 million people (aged 15 - 49) were estimated to be living with HIV (UNAIDS, 2015). In order to address the rapid proliferation of HIV throughout the country, Voluntary Counselling and Testing (VCT) services were implemented nationally in 2004 in order to establish individuals' HIV status and manage and counsel patients who tested positive for the virus to receive treatment and improved quality of life timeously.

Within the medical discourse genre, the importance of distinguishing medical consultations as a significant and regularly structured discourse in itself has been emphasised. Accordingly, different instances of health care professional-patient communication have received attention in research. As a conversational subtype of medical discourse, pre-test VCT counselling in VCT has not yet been characterised in scholarly work. The aim of this study is to identify the generic features of this particular form of medical conversation in which counsellors are required to follow protocol in informing patients regarding various HIV-related topics as well as ensuring that the patient sufficiently understands this information in order to make an informed decision regarding giving consent for the test to be administered.

Situated in the subfield of Linguistic Pragmatics, this study provides a qualitative analysis of data collected from two state health care facilities in rural towns in the Western Cape Winelands district consisting of 14 pre-test VCT counselling sessions conducted in Afrikaans. Participants include counsellors and patients. The counsellors have no medical training but passed at least grade 12 at school and have limited, dedicated preparation for counselling in HIV care. They are recruited from the local community. Patients show diversity in terms of the reason for their visit to the clinic; depending on the area where the clinic is situated, there is mostly also considerable linguistic diversity.

By applying methods set out in the theoretical framework of Conversation Analysis (CA) as developed by Sacks, Schegloff and Jefferson (1974), this study investigates the sequential organisation of speech acts in order to find recurring patterns on the basis of which generic features of pre-test VCT counselling sessions are identified. A clear imbalance of spoken participation between participants indicates that counsellors dominate these conversations by mostly taking the role of speaker in centering the bulk of the conversation around information-giving sequences. Then the patient, who is unfamiliar with the context and its

procedures, mostly takes a passive role as listener in the conversation. When the listener role is the primary one within a particular interaction as in this case, the hearer contributions typically take on a form that is identified as meaningful signs and signals addressed at the speaker, termed “hearer signals”.

Since a concentrated presence of hearer signals is a generic feature of these conversations, this study further uses Corpus Linguistics in order to recognise and characterise the hearer signals according to form and function. These signals are divided into verbal and nonverbal categories and are contextually, pragmatically and intuitively found to contribute to the conversation in many ways. While the majority of signals produced in this conversation take the form of nonverbal signals such as head nods as well as short verbal utterances, they are mostly produced to function as acknowledgers, continuers, confirmation of received speech and reactions to specific prompts in the counsellor’s speech.

In summary, both the analyses of the generic features of VCT and hearer signals used in these pre-test VCT counselling sessions reveal the counsellor-centred nature of these conversations. By rigidly structuring the conversation according to protocol, counsellors create constraints through which patients are constructed as passive participants and are all treated similarly despite showing diverse levels of knowledge and needs. They are, for example not often granted a speaking turn, are easily interrupted or brought to close their turns quickly. In this way the communicative aims of this type of conversation were found not to be fully accomplished.

This study gives a conversational analytic characterisation of VCT consultations and a linguistic pragmatic characterisation of the hearer signals that occur in VCT. It can contribute to better understanding and managing an area of HIV health care where treatment of relatively vulnerable patients is dependent on achieving mutual understanding between interactants. The findings can be applied (e.g.) in developing new training programs aimed at equipping VCT counsellors to develop a patient-centred approach by shifting the focus from almost rote distribution of information to transferring more agency to the patient within these consultations.

OPSOMMING

MIV en VIGS is sedert die 1980s 'n kommerwekkende nasionale gesondheidskwessie in Suid-Afrika. Na beraming het daar teen 2014 'n getal van 6,8 miljoen mense tussen die ouderdomme van 15 en 49 met MIV geleef (UNAIDS, 2015). Vrywillige Berading en Toetsing (VBT) is in 2004 landwyd geïmplementeer om die verspreiding van MIV te beperk. Die VBT-dienste is ingestel om die MIV-status van individue te bepaal en om diegene wat positief toets met berading by te staan ten einde tydige toegang tot die nodige behandeling en gepaardgaande verbetering van lewenskwaliteit te bied.

Binne die groter genre van mediese diskoerse, is mediese konsultasie uitgewys as 'n belangrike diskoerstipe wat reëlmatig gestruktureer is en dus in eie reg bestudeer behoort te word. So is daar reeds wetenskaplike aandag aan verskillende instansies van kommunikasie tussen gesondheidsorgdeskundiges en pasiënte gewy. As 'n gespreksstipe binne mediese diskoers, is pre-toets MIV-berading in VBT tot dusver nie in wetenskaplike publikasies beskryf nie. Die protokol waarvolgens pre-toets VBT-berading gedoen word, verplig beraders om pasiënte in te lig aangaande verskeie MIV-verwante onderwerpe terwyl hulle ook moet verseker dat pasiënte genoegsame begrip van hierdie informasie toon om 'n ingeligte besluit te kan neem rakende hulle instemming tot MIV-toetsing. Die doel van hierdie studie is om die generiese eienskappe van hierdie spesifieke mediese gesprekstipe te identifiseer.

Hierdie studie is gesetel in die terrein van Taalwetenskaplike Pragmatiek en bied 'n kwalitatiewe analise van data wat ingesamel is by twee staatsbeheerde gesondheidsorginstansies in landelike dorpe in die Wes-Kaapse Wynlanddistrik. Die data bestaan uit 14 pre-toets MIV-beradingsessies wat in Afrikaans uitgevoer is. Die deelnemers is beraders en pasiënte. Beraders is in die plaaslike gemeenskap gewerf; hulle het geen mediese opleiding nie, maar het minstens graad 12 geslaag. Hulle het wel beperkte, MIV-beradingstoegewyde voorbereiding vir die werk wat hulle in die klinieke doen. Pasiënte vertoon diversiteit ten opsigte van die rede vir hulle besoek aan die kliniek. Verder verseker die ligging van die klinieke 'n redelik hoë mate van talige diversiteit onder die pasiënte.

Met behulp van metodes ontwikkel binne die teoretiese raamwerk van Gespreksanalise (*Conversation Analysis* (CA)) (sien Sacks, Schegloff & Jefferson, 1974), ondersoek hierdie studie die organisatoriese elemente onderliggend aan die opeenvolging van taalhandelinge ten einde herhalende patrone te herken op grond waarvan generiese kenmerke van pre-toets MIV-

beradingsgesprekke geïdentifiseer kan word. Die manier waarop beraders deurentyd die rol van spreker inneem en gesprekke oorheers deur die meerderheid taalhandelinge te sentreer en orden rondom die oordrag van inligting, verseker 'n ongelyke verdeling van spreekbeurte. Aan die pasiënte wat nie met die konteks en prosedures vertrou is nie word dan 'n passiewe luisteraarsrol in die gesprek toegeken. In só 'n geval waar die pasiënt primêr 'n luisteraarsposisie inneem, bestaan hoorderbydraes tipies uit betekenisvolle tekens wat as “hoordertekens” aan die spreker gerig is.

Aangesien hierdie gesprekstipe kenmerkend 'n hoë konsentrasie van sulke hoordertekens bevat, word hierdie tekens gekarakteriseer met verwysing na hulle vorm en funksie. Binne dié hoordertekens word verbale en nie-verbale kategorieë onderskei wat op kontekstuele, pragmatiese en intuïtiewe vlak op verskeie maniere bydra tot die gesprek. Die meerderheid van hierdie tekens is nie-verbaal (soos kopknikke of kort spraakklankuitings) en word meestal geproduseer ter erkenning of bevestiging van die sprekerbydraes, in aanmoediging van die voortsetting van die gesprek of in reaksie op spesifieke taalstimuli van die spreker/berader.

Om op te som: sowel die analyses van die generiese eienskappe van VBT-gesprekke as van die hoordertekens wat in die pre-toets MIV-beradingsgesprekke voorkom, bevestig dat hierdie gesprekke oorweldigend beradergesentreerd is. Beraders se rigiede strukturerings van hierdie gesprekke om protokol na te kom, plaas beperkinge op die gesprek wat die pasiënte tot passiewe deelnemers reduceer wat almal eenders behandel word ten spyte van waargenome diversiteit in terme van kennis en behoeftes. Hulle word byvoorbeeld selde 'n spreekbeurt gegun, word maklik in die rede geval of verplig om hulle beurt vinnig te beëindig. Gevolglik is bevind dat beraders nie die kommunikatiewe doelwitte van die gesprekstipe ten volle verwesenlik nie.

Hierdie studie bied 'n gespreksanalitiese karakterisering van VBT-konsultasies en 'n pragmatiese karakterisering van hoordertekens wat voorkom in VBT. Dit kan bydra tot beter begrip en bestuur van 'n area in MIV-sorg waar die behandeling van kwesbare pasiënte afhanklik is van wedersydse begrip tussen gespreksdeelnemers. Die bevindinge kan toegepas word in byvoorbeeld die ontwikkeling van nuwe opleidingsprogramme met die oog op toerusting van VBT-beraders om 'n pasiëntgesentreerde benadering in konsultasies te volg. Dit sal behels dat die fokus van die konsultasies verskuif van 'n geroetineerde vorm van inligtingoordrag na die skep van geleenthede waarbinne pasiënte op bevryde wyse meer onafhanklike bydraes tot die gesprek kan maak.

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LIST OF ABBREVIATIONS AND ACRONYMS

AAA	–	Accompanied pre-/adolescent patients from clinic A
AIDS	–	Acquired immunodeficiency syndrome
AMI	–	Mothers testing infants from clinic A
ART	–	Antiretroviral treatment
ARV	–	Antiretroviral
ATICC	–	AIDS Training Information and Counselling Centre
BMMC	–	Medical male circumcision patients from clinic B
BRF	–	Referred female patients from clinic B
BRM	–	Referred male patients from clinic B
CA	–	Conversation Analysis
CDC	–	Centers for Disease Control and Prevention
ELISA	–	Enzyme-linked immunosorbent assay
HCP	–	Health care provider
HIV	–	Human Immunodeficiency virus
L1	–	First language
L2	–	Second language
L3	–	Third language
MMC	–	Medical male circumcision
NDoH	–	National Department of Health
PanSALB	–	Pan South African Language Board
PLHIV	–	People living with HIV
PMTCT	–	Prevention of mother to child transmission
SA	–	Summons-answer
STI	–	Sexually transmitted infection
TB	–	Tuberculosis
VCT	–	Voluntary counselling and testing
WCDoh	–	Western Cape Department of Health
WHO	–	World Health Organization

LIST OF KEY TERMS

Conversation

The noun ‘conversation’ refers to informal talking between at least two people, during “which news and ideas are exchanged” (Stevenson, 2010:381). Schegloff and Sacks (1982:71-72)¹ propose two basic features of conversation: that (i) “at least, and no more than, one party speaks at a time” and that (ii) “speaker change recurs.”

Conversation Analysis (CA)

By studying everyday instances of talk-in-interaction, CA is concerned with describing “the *structures*, the *machinery*, the *organi[s]ed practices*, the *formal procedures*, the ways in which order is produced” by analysing the frequency of specific phenomena in order to provide a formal description of the orderliness and organisational structures of social (inter/)action (Psathas, 1995:2-3, italics in original).

Medical discourse

‘Discourse’ refers to language in interaction, whether spoken or written text. Regardless of its form, discourse includes “anything beyond the sentence” (Tannen, 1986:6). Its properties include that it “forms structures ..., conveys meanings ..., and accomplishes actions” (Schiffrin, 1987:6). ‘Medical discourse’ can thus be defined as interactional language used in the context of a medical institution. An important aspect regarding spoken discourse – the focus of this study – is the fact that the language should be recognised by the hearer as coherent in the context, despite the possibility that it could not conform to the formal grammatical rules of the language (Cook 1989:7). Features of discourse will vary from one context to another, depending on whether it is written or spoken language, and whether it occurs in a formal or informal environment. Bührig and Meyer (2004:46) e.g. suggest that language forms and patterns used in institutional types of discourse are shorter than in other contexts.

¹ “This is an expanded version of a paper originally delivered at the annual meeting of the American Sociological Association, San Francisco, September 1969. It appeared in *Semiotica*, Vol. 8, 1973, pp. 289-327. Bibliographic update July 1982, reprinted with permission of Emanuel A. Schegloff.”

Hearer signal

The verbal and nonverbal signals that the person who does not have the speaking turn produces to acknowledge reception of a speaker's information with the goal of confirming that s/he is in fact the listener (Bublitz, 1988:169). While the speaker is occupying the main channel of communication, hearer signals are produced in the "back channel" (Yngve, 1970) fulfilling a number of conversational functions. By producing these signals, the receiver of speech acts exerts her/his "right to speak at any time" (Bublitz, 1988:169).

Sign

There exist many theoretical reflection on the typology of sign models within the field of semiotics (cf. Nöth, 1990:79-84). Generally, a sign is "a meaningful unit which is interpreted as 'standing for' something other than itself" (Chandler, 2007:260). It can take the physical form (the 'sign vehicle') of "words, images, sounds, acts or objects" and carries the meaning within a "recognised code" which is assigned to it by its producer (Chandler, 2007:260).

Signal

As with 'sign', the term 'signal' is defined and used in various fields (cf. Sebeok, 1986:951-952). For the purposes of this study, a 'signal' is defined as a "[sign] of communicative intent which, unlike complete sentences, lacks a subject-predicate structure" (Clarke, 1987:90, cited in Nöth, 1990:113). Clarke (1987:90, cited in Nöth, 1990:113) provides "simple gestures ... and single word utterances" as examples of signals in communication.

Talk-in-interaction

Coined by Schegloff (1987:207), this term aims to include a wider variety of spoken discourses than 'conversation'. Although the two terms can be used interchangeably (Richards & Schmidt, 2002:122), "conversation" denotes informal interaction on which no external purpose is imposed (Reed, 2011:6). "Talk-in-interaction" refers to all types of talk, including more structured forms of talk found in an institutional context, such as the one where this study was conducted.

Voluntary Counselling and Testing (VCT)

VCT is the service formed as supplementary to regular medical support for determining the HIV status of people with a view to timeous diagnosis and treatment with a view to containing the AIDS epidemic. VCT consists of three parts: pre-test counselling, the test itself and post-test counselling.

Chapter One

OUTLINING THE STUDY

1.1 INTRODUCTION

This study investigates particular linguistic features that typically occur in HIV counselling and testing consultations in state health care facilities in rural communities in the Western Cape. Specifically, it takes a scholarly interest in the conversational structure of voluntary counselling and testing (VCT)² consultations in which a counsellor meets a patient before the HIV test is taken to ensure that the patient is well informed on the nature of the HI-virus, what the test can and cannot indicate, and what the implications are of the outcome. One component of all medical consultations, and also of VCT consultation, is the verbal and nonverbal signals given by the listener (who is mostly the patient) in the counselling session. This study investigates hearer signals produced as components of the VCT conversation among Afrikaans first language (L1) speakers in two rural HIV and AIDS care clinics. These signals are followed in the context of HIV counselling and testing not only because the use of such signals can be pervasive in such a context, but also because they appear to be critical for effective treatment as they tend to form the bulk of the hearers' linguistic contribution, occur frequently and carry significant contextual meaning. There is a large body of knowledge on the features of spoken language that contribute to meaning making, and that do not feature as such in written language (cf. Carter & McCarthy 1995, Leech 1998, Willis 2003, Willis & Willis 2007, Cheshire 2007, Cheshire, Kerswill, Fox & Torgensen 2011). This study is one of the first in a South African context to consider specifically the kinds of signals hearers give in indicating their continued participation in conversation where two or more participants are engaged. Although compared to speakers elsewhere, South African hearers are not necessarily expected to produce a different set of signals, this study does introduce, for the first time, hearer signals produced by L1 Afrikaans speakers in the context of medical care. This having been said, the study aims to contribute knowledge to current reflection on the production and functions of hearer signals, across different languages and national contexts. It is situated in the context of medical consultations where on the one hand the patient needs to indicate

² Although the abbreviation, HCT (HIV Counselling and Testing) is also found, in order to remain consistent, this study will make use of VCT as the abbreviation referring to HIV Counselling and Testing.

her/his understanding and agreement or disagreement, and on the other hand the health care professional (HCP) (counsellor, nurse or physician) needs to recognise the spoken contribution that the patient (and possible other participants) make during the consultation.

1.2 BACKGROUND AND RATIONALE

The human immunodeficiency virus (HIV) which can lead to acquired immune deficiency syndrome (AIDS) if left untreated, remains a major concern of public health in South Africa. This dissertation reports on a study for which data was collected in 2014 when 6.8 million people (aged 15 – 49) were estimated to be living with HIV (UNAIDS, 2015). In the years before this study was conducted, the Western Cape had the highest increase in its rate (from 3.2% in 2005 to 7.8% in 2012) of people living with HIV (PLHIV) of all the nine South African provinces. Since the first diagnosis of patients with AIDS in 1983 (Ras, Simson, Anderson, Prozesky & Hamersma, 1983) and with the rapid proliferation of the disease in the country, HIV VCT services were developed to address this as a national health care concern. As the epidemic grew, however, so did the requirement of HCPs dedicated to HIV and AIDS care. This included a need for counsellors, a community of health care workers with minimal formal education who could assist with a communicative aspect of care, namely giving out information and support, also as lay counsellors. Although currently these counsellors are equipped in terms of technical skills and sufficient biomedical knowledge, they do not necessarily have the necessary social skills for mediating successfully in this context (Argyle, 1983:57).

Anthonissen and Meyer (2008:3) indicated that “successful treatment of HIV-related illnesses, and particularly gaining desirable results from Antiretroviral (ARV) treatment, appears to be dependent on successful communication between clinic staff and patients”. The biggest obstacles to this communication are linguistic barriers which are fixed within the structural foundation of public health care and threaten the post-apartheid ideal of providing equitable and efficient health care for all patients (Deumert, 2010). In his study of intercultural doctor-patient communication, Rehbein (1994:83) found that many of the communicative problems that are encountered in social groups and societies do not just lie in “superficial misunderstandings but in far-reaching communicative structures”. This indicates that shared knowledge of the same language alone does not guarantee communicative success. As will be highlighted in this study, a shared linguistic repertoire between HCP and

patient does not necessarily guarantee successful and mutual understanding within HIV counselling sessions.

In early studies of the structure of language, particularly the structure of language units larger than sentences, it was assumed that for spoken discourse where there exists no prior script, the structure of free conversation could only be random, haphazard and largely irregular. In contrast and after reflection on the structure of speech acts of various kinds, Austin (1962), by exploring the underlying function and causality of text, initiated a shift from the study of the literal meaning of text, to the use and function of spoken text within its social context. Within the consequent development of pragmatics, Searle (1969:17) established that conversational behaviour is rule-governed and that its features can be studied independently of other forms of language use. He stressed, however, that it would be inappropriate to investigate these formal features of spoken interaction separate from their role or function in the conversation. It is therefore important that researchers who are interested in structural features of texts and discourses (which include conversation) not only focus on core elements in a theoretical form, but also consider the practical context in which the speech is produced and interpreted.

Within the development of Speech Act Theory, Austin (1962) and Searle (1969) emphasised the importance of investigating the intention behind speech acts in their context. Goffman (1964) then introduced the social situation as a previously neglected, influential factor that should also be taken into account. This is then “an environment of mutual monitoring possibilities, anywhere within which an individual will find him- or herself accessible to the naked senses of all other who are ‘present,’ and similarly find them accessible to him” (Goffman, 1964:135). Within this situation, influential variables can be found ranging from individuals’ social roles to linguistic and extralinguistic factors.

After drawing attention to studying ordinary instances of speaking in its social setting, Goffman (1955:1963) claimed that interaction is socially organised. Sacks (1992), through his lectures on conversation in the 1960s, expanded on this approach by introducing the study of social action by investigating the construction of social order through everyday talk. These developments then led to the establishment of the field of Conversation Analysis (CA), in which Sacks et al. (1974) set out to characterise the organisation of talk.

In short, CA aims to make sense of the orderliness and organisation of human (inter/)actions; a CA analyst is interested in describing “the *structures*, the *machinery*, the *organi[s]ed*

practices, the *formal procedures*, the ways in which order is produced” by analysing the frequency of specific phenomena in order to provide a formal description of the structures of social (inter/)action (Psathas, 1995:2-3, italics in original). With its initial aim to examine everyday social interaction, Heritage (1997:162) introduced a second approach within CA which he calls “institutional interaction” that “studies the management of social institutions *in interaction*” (italics in original).

Institutional CA studies the features of institutional interaction which are formed around the specific structures and procedures inherent to the nature of the institutional context at hand (Drew & Heritage, 1992:21-25). The advantages of approaching the analysis of doctor-patient interactions from an Institutional CA perspective, for example, are reported to provide insightful contributions to this field. It enables researchers (i) to recognise specific behavioural patterns and how these are treated by HCPs, (ii) to classify techniques employed to enhance patient-centred behaviour interaction, and (iii) to analyse the relation between specific styles of interaction with observed outcomes (Drew, Chatwin & Collins, 2001:59). Mishler (1984:7-8) acknowledges the importance of distinguishing medical interviews as a discourse in itself that should be recognised and handled in a serious light as he argues that by investigating the workings of this discourse, one can gain a better understanding of the doctor and patient’s collaborative work – a crucial part of clinical practice. Also, once systematic structures and patterns have been recognised and described, the regularities can be addressed in training of HCPs.

The specific discourse genre in which this study is situated is pre-test VCT counselling sessions as medical conversation. These pre-test counselling sessions are obligatory protocol in the HIV and AIDS treatment regime and require counsellors to cover a certain set of topics before continuing with the blood test. It is also required that patients show understanding of the complex information conveyed to them. Due to the information giving character of the protocol within this discourse as it is taught to counsellors, it is not unexpected that the counsellor will mostly hold the floor, providing for sequences consisting of long monologue-style, rhetorically rigid counsellor information-giving statements, a typical feature of this interaction is an imbalance in turn-distribution between counsellor and patient. For this reason, the use of hearer signals is not only prevalent, but also taken to be a critical component of effective treatment. Through this communicative event, counsellors assess the

preparedness of patients who have a positive HIV-test outcome, to use a quite onerous health care regime.

According to Peräkylä (1995:28) “it is an intrinsic feature of conversational interaction that its participants exhibit continuously their understanding of one another’s conduct”. Although it is something that every individual is faced with on a daily basis, the hearer signal as a communicative phenomenon has not been the subject of many scientific investigations. As early as 1952, Fries set out to categorise utterances in order to describe different kinds of sentences. He defines hearer signals as “single free utterances” (or head nods) that conventionally provide feedback to the speaker regarding her/his ongoing attention to the speaker’s talk (Fries, 1952:49). It has also been called “concurrent feedback” (Krauss & Weinheimer, 1966), “minimal responses” (Bennett & Jarvis, 1991; Fellegly, 1995; Stubbe, 1998), “listener responses” (Dittmann & Llewellyn 1967, 1968; Kraut, Lewis & Swezey, 1982; White, 1989; Bavelas, Coates & Johnson, 2002; Xudong, 2008), “acknowledgement tokens” (Jefferson, 1984; Drummond & Hopper, 1993); and “reactive tokens” (Clancy, Thompson, Suzuki & Tao, 1996; Young & Lee, 2004). In his research on the listener’s role in conversation, Gardner (2001) reviews the literature on what he refers to as “response tokens”. His short definition provides for “conversational objects that indicate that a piece of talk by speaker has been registered by the recipient of that talk” and can be interpreted as discourse information on the way the interaction is progressing (Gardner, 2001:13).

Although these signals take the form of verbal (utterances such as “hmm” and “okay”) and nonverbal (including head nods, gesturing and facial signals) feedback behaviour from the listener (Kendon, 1967) and are produced through the back channel (Yngve, 1970), it can function to contribute to interaction in a variety of ways. These linguistic phenomena have been suggested to take the form of continuers (Schegloff, 1982), assessments (Goodwin, 1986), different kinds of acknowledgement (Schegloff, 1982; Bublitz, 1988; Gardner, 2001) or “information management” (Schiffrin, 1987:73-101) and ways to show that the interest of speaker and hearer is aligned (Bublitz, 1988:195; Lambertz, 2011). It has furthermore been found to comment on contextual formality (Bennet & Jarvis, 1991), or to influence a speaker in indicating a hearer’s expectations or attitude (Rodrigues, 2008:215), as well as interest (Gardner, 2001:14) towards a speaker’s actions. Regardless of its observed contribution within context, hearers can simply automatically produce these signals in an attempt to feign understanding, rather than expressing it (Schegloff, 1982:78; Bublitz, 1988:172).

Within a South African context, using data from two HIV day clinics in the Western Cape, this study firstly investigates the VCT pre-test counselling session as a type of conversation that has not been characterised in literature before. This is done from a conversation analytic approach in order to identify the generic features of this kind of medical consultation. It secondly reports on the kinds of hearer signals encountered in these HIV counselling sessions conducted in Afrikaans. It is the first in a South African context to consider specifically the kinds of signals hearers give in indicating their continued participation in conversation where two or more participants are engaged. Situated in this medical consultation, on the one hand the patient needs to indicate her/his understanding and (dis)agreement, and on the other hand the HCP needs to recognise these verbal and nonverbal contributions that the patient (and possible other participants) make during the consultation in order to recognise whether the patient is following or understanding.

1.3 PROBLEM STATEMENT

The problem that this study addresses pertains to the ways in which recipients of information signal to the informant that they are following and actively participating in a conversation. The same person in one speech event is at certain times the speaker and at other times the hearer; however, when the listener-role is the primary one within a particular interaction, the hearer-contributions typically take on a form that is identified as meaningful signs and signals addressed at the speaker. These may be formal elements of language such as words or non-linguistic cues such as tongue clicks that could also be meaningful. Such hearer signs and signals are topicalised in order to describe and analyse their particular form, meaning and communicative function. The kinds of conversations that are investigated to address this problem, are structured and semi-structured medical consultations in which such hearer signals not only occur often, but in which they are crucial in determining the communicative success of the encounter.

Thus, the problem being addressed is our limited information on how hearer signals (of which many, in linguistic pragmatic terms, are identified as ‘discourse markers’) are used and what kinds of meaning are assigned to them by various participants. The problem is related to our knowledge of the features of spoken discourse. Hearer signals in this context are specifically singled out as they form the bulk of the patients’ linguistic contribution within these conversations.

An important goal of VCT is to ensure that a patient understands the nature of HIV as well as the ways to prevent the spread of the virus. In these rural communities a significant proportion of the population has not completed 12 years of schooling, so that low literacy levels are prevalent. This means that counsellors need to convey rather sophisticated biomedical information in a user-friendly manner in order to promote optimal understanding among patients. Understanding of the virus is taken to be crucial as such knowledge is what most likely will change risky behavioural patterns; in turn, such change ultimately will lead to curtailing the spread of HIV in South Africa. Furthermore, according to protocol, an individual is not advised to start with Antiretroviral Treatment (ART) unless her/his understanding of this information is clear. Therefore, since patients do not take the speaker role often in this context, accurate interpretation of the hearer signals to reflect a patient's level of understanding, is essential.

Despite the constitutionally provided rights and consequential efforts to promote equal development and usage of all South African languages throughout the Western Cape, linguistic barriers in health care communication are commonplace. A further problem this study addresses is that there is evidence of misunderstandings that occur due to structural constraints of HIV counselling sessions. Such misunderstanding could jeopardise the quality of medical care while also marginalising and alienating particularly vulnerable patients.

This study investigates the genre of medical discourse, and specifically HIV counselling where people with limited professional certification mediate in administering the test and facilitating the counselling process. These people are trained to follow protocol which requires of them to ensure patients are informed about HIV, its nature, ways of transmission, kinds of treatment, etc. It is crucial to analyse the form, structure, and specifically linguistic features of these sessions in order to assess, to a reasonable extent, the degree of success VCT counselling achieves.

Taking a CA approach to analyse pre-test counselling sessions within VCT will give new insight into the form and function of sequentially organised actions and the uses of hearer signs and signals so that their form, meaning and communicative functions become clear.

1.4 RESEARCH AIMS AND OBJECTIVES

The aim of this study is to collect a corpus of spoken language in authentic pre-test VCT counselling sessions with a view to addressing the problems referred to above. Concretely, the study intends to achieve the following aims:

- (i) to identify the generic features of pre-test VCT counselling as a particular form of conversation;
- (ii) to identify the forms of hearer signs and signals that occur in such spoken communication, referring to (e.g.) particular sounds, words and phrases, tone, accompanying nonverbal signs and signals such as facial expression, body language, and the likes;
- (iii) to interpret the hearer signs and signals that occur in this context in terms of their function within the context;
- (iv) to select the most widely used forms for specific analysis regarding
 - their use in signalling understanding, uncertainty, agreement, objection, etc.
 - the contribution they make to the overall structure of the encounter

1.5 RESEARCH QUESTIONS

In order to achieve the aims set out in 1.4 above, the following specific research questions will be addressed:

- (i) What are the generic features of VCT counselling as communication in a formal pre-test HIV consultation?
- (ii) What are the hearer signs and signals that occur in the spoken language in HIV medical encounters, specifically the VCT consultation between patients and counsellors as HCPs?
- (iii) How do hearer signs and signals that occur in this context function and carry meaning?
- (iv) Considering the most widely used hearer signals in the data,
 - which forms are typically used by the primary speaker and the hearer in assigning understanding, uncertainty, agreement, objection, etc.?

- what contribution do these hearer signals make to the overall structure of the encounter?

1.6 THEORETICAL FRAMEWORK

The same person in one speech event is at certain times the speaker and at other times the hearer. However, when the hearer-role is the primary one within a particular interaction, the hearer contributions typically take on a form that is identified as meaningful signs and signals addressed at the speaker. From a Linguistic Pragmatics approach, this study is firstly interested in describing the generic features of pre-test VCT counselling sessions as a conversation type within medical discourse.

As a type of conversation, the VCT is structured towards the aim of transmitting information and assuring that the patient knows how to deal with the information, depending on the outcome of the test that is to follow. In Conversation Analytic terms, the consultation has a very specific turn-taking structure. It takes the form of a combination of sequences in which one participant (the counsellor) mostly plays the role of the speaker who delivers information, and the other (the patient), that of the hearer.

Secondly the study is interested in describing how hearers (i.e. patients) – to whom the speaker role is rarely assigned – indicate that they are actively participating in the conversation. In order to understand hearer signals and their significance in HIV and AIDS treatment, comprehension of the conversation type and its generic features is crucial.

The theoretical framework within which this study is conducted is that of CA as developed by Sacks et al. (1974). With its focus on the orderly and sequential organisation of speech acts, CA is used to identify those features which typify the pre-test VCT conversation. The three interrelated levels on which the analysis focuses are (i) individually designed turns of talk that together form (ii) sequence structures representative of interactional activities or tasks which in turn, are assembled to form the (iii) structure of the consultation as a whole (Heritage & Maynard, 2006:13). All utterances or communicative acts perform contextual social actions which are sequentially connected (Drew et al., 2001:59). CA is concerned with identifying the behavioural patterns formed by these sequentially connected events in order to develop theories regarding the uses and structured properties of the conversational practices of the discourse at hand (Heritage, 1995:399).

1.7 RESEARCH DESIGN AND METHODOLOGY

1.7.1 Qualitative Research

This study is a qualitative research project situated within the area of Linguistic Pragmatics (cf. section 3.2.1) in which (i) specific generic characteristics of conversation determine the methodological approach to lay the foundation in which specific attention can be given to (ii) the verbal and nonverbal discourse markers used by listeners in a given conversation type. CA with its focus on the sequential ordering of spoken language dictates the methodology that is used for characterising pre-test VCT consultation. Detailed examinations of the conversations of a small number of participants will be used to provide a naturalistic description and interpretation of institutional talk in interaction in the form of counsellor-patient communication within the medical context of VCT in HIV care. Using Corpus Linguistics, the recorded data will be transcribed to facilitate the recognition of hearer signals and their communicative functions. These are also identified and characterised in terms of their interactional contribution.

1.7.2 Context and participants

Data were collected from two day care clinics in rural towns in the Winelands district of the Western Cape. Twenty HIV pre-test counselling sessions were recorded at clinic A of which six were conducted in Afrikaans, eight in isiXhosa, three in English, two in which an interpreter was used to interpret from isiXhosa (from the counsellor) to Sesotho (to the patient), and one case of a Shona L1 speaker with rudimentary English who, after a brief attempt in English, could not be accommodated on the particular day. Twelve sessions were recorded at Clinic B of which eight were conducted in Afrikaans, three in isiXhosa and one in English. Although a number of multilingual sessions were recorded in which counsellor and patient had different linguistic repertoires, due to the excessive volume of the recordings and the complexity of the variables, only the sessions conducted in Afrikaans were selected for analysis in this study. Thus in total 14 counselling sessions were closely scrutinised and used in the analyses presented in the dissertation.

The data were collected during a time in which seasonal workers from different provinces as well as neighbouring countries were working on farms in the region. Such migration is regular during the harvesting time since the primary agricultural and economic activity in both these towns is fruit farming. The majority of the migrating workers are citizens of

Lesotho and Zimbabwe whose L1s are predominantly Sesotho and Shona respectively. These foreign workers bring a larger degree of linguistic diversity to the clinics than just the local languages, so that the full collection of interactional data illustrates a large array of forms of intercultural and multilingual communication. Although the data collected from these migrants did not form part of the analysis, its value for future studies cannot be underestimated.

1.7.3 Data collection methods

After obtaining ethical clearance from both the Research Ethics Committee: Human Research (Humanities) of the University of Stellenbosch as well as the Western Cape Department of Health (WCDoH), the relevant officers at the two clinics were approached for their permission to collect data at their HIV care facilities. Appointments were made to do the data collection at times that would not be disruptive to the regular working programmes of the clinics and to minimise intrusion regarding the counsellors and patients.

Data were collected using two types of research instruments, namely video and audio recordings. The data consists of pre-test VCT counselling sessions of which the recordings run from the moment the participant enters the counselling room until before the participant signs the medical consent form required before blood will be drawn for testing. Both the video camera and dictaphone were operated solely by the researcher who was present at the clinic, but not in the room during the sessions. Before the counselling session began, the researcher turned on both devices and then left the consultation space. She was then called back into the counsellor's office by the counsellor at the end of the session in order to turn off the devices.

1.8 CHAPTER OUTLINE

The presentation of the study in the following chapters will proceed as follows:

Chapter two provides the contextual background in which this study is grounded by firstly investigating the status of HIV/AIDS in South Africa and more specifically the Western Cape. In doing so, the geography, population and linguistic diversity of this province are reported on, with specific focus on linguistic barriers that exist in health care communication and on existing attempts to overcome this. This chapter concludes by presenting an overview of the procedures prescribed for VCT in its attempt to provide ART to South Africans.

Chapter three gives a review of literature used in this study. Firstly, an overview is presented of the study of spoken interaction within the linguistic field of Pragmatics. Face-to-face talk-in-interaction is introduced here by discussing the building blocks of dialogue within the social situation. Secondly an overview is given of theoretical concepts within CA with specific focus on the application thereof in institutional settings where spoken discourse is the primary means of communication. Then, counsellor-patient communication as a genre within

medical discourse receives attention in light of its procedural structure as well as the challenges found in this kind of discourse. Lastly, research on hearer signals is reviewed with specific emphasis on the features, functions and variety of signals provided by the hearer as co-participant during conversation.

Chapter four introduces the research design and methodological approach taken in this study. While the context in which this study is located and provide a detailed description of its participants are defined, ethical considerations are also discussed, and information about gaining permissions for the research is given. The process of data-gathering will be described in detail, also motivating the choice to use multimedia, i.e. video recordings as well as audio recordings. This chapter includes a description of tools and procedures used in processing the data and an overview of the methods used in data analysis to be presented in chapters five and six.

Chapter five uses instruments suggested by CA for describing and interpreting the quite rigid structure of the pre-test VCT counselling session. With the aim of identifying recurring patterns of turn-taking within this specific discourse, this analysis investigates four types of sequences found within its structure as a whole: opening, closing, question-answer, and information-giving sequences. Throughout these sequences and especially within the last mentioned sequence type, attention will be given to hearer responses. Using Corpus Linguistics, a list of verbal and nonverbal hearer signals is presented in chapter six. After providing a general inventory, theories regarding their communicative functions are considered, after which an overview is given of hearer signals that were found within each conversation category. This is set out and defined in section 4.3.2.

Chapter seven concludes by offering a summary of the findings presented in the analyses set out in chapters five and six. This chapter will show how the expositions given in chapters five and six contribute to achieving the aims of the study and thus also answering the research questions. An overview of the structural features of pre-test VCT counselling sessions as analysed by means of the theoretical framework of CA will be given. In doing so, an interpretation will be offered regarding the extent to which the communicative goals of VCT are being met, after which some social concerns relating to the system will be presented. This final chapter will consider the limitations of the study, will suggest further work stemming from this project and will also make suggestions as to the uses of the findings for improved communicative practices in VCT counselling.

Chapter Two

SITUATIONAL CONTEXT

2.1 INTRODUCTION

This chapter provides background regarding the context in which this study is based. It starts by identifying the development of HIV/AIDS in South Africa and the Western Cape (2.2) as the problem to which a solution in the form of ART (2.3) is proposed, after which some information on VCT (2.4) is also provided. Within the South African health care system (2.5) as the setting in which VCT takes place, linguistic diversity and national policy in South Africa (2.6) cannot be overlooked. By finally narrowing the focus to the situational context of the Western Cape (2.7) as well as challenges in health care communication (2.8), this information contextualises the study, to indicate the conditions generally in which VCT services are provided so that the generic features of pre-test VCT counselling become clear. The idea is to establish how speakers and hearers currently structure and manage counselling sessions in terms of turn-taking, hearer signals and associated conversational features which may in future assist in managing the transfer of critical health care information better than present practices do.

2.2 HIV/AIDS IN SOUTH AFRICA AND THE WESTERN CAPE

On a global scale, HIV remains a major concern in public health, as about 36,9 million people have been reported to be living with AIDS at the end of 2014 with 2 million newly infected people globally throughout 2014 (WHO, 2015). AIDS has been declared the “world’s leading cause of death by an infectious disease” and at the time of data collection, the estimated number of new HIV infections on a daily basis worldwide was 7000 (Stine, 2014:309).

2.2.1 HIV/AIDS in South Africa

The first case of AIDS in South Africa was officially reported in 1983. At this time, HIV type one (HIV-1)³ was categorised as an isolated subtype B epidemic⁴ mostly prevalent among

³ HIV can be classified as either type one (HIV-1) or type two (HIV-2). HIV-1 was named such after the initial description in 1983 and the virus found in West Africa thereafter was called HIV-2 (Corbitt, 1999:23). In short, HIV-1 is more infective, consequently accounting for the majority of cases found in the world (Gilbert,

men who have sex with men, haemophiliacs, as well as individuals who receive unscreened blood products. It then developed to its current status as a generalised, established, subtype C epidemic⁵ (Abdool Karim & Abdool Karim, 2005:49).

As reflected in figure 2.1 overleaf, Sub-Saharan Africa remains the most affected area with an estimated 19 million PLHIV in East and Southern Africa in 2015 (UNAIDS, 2016). Additionally, this area contributes about 46% to all global HIV infections (UNAIDS, 2016). Since 1997 South Africa, a country which experienced one of the world's most rapid growths in the HIV epidemic, has been ranked the country with the highest prevalence of PLHIV within the Sub-Saharan region. In 2014 (when data for this study was collected) it was estimated that 6.8 million people between the ages of 15 and 49 were living with HIV in South Africa (UNAIDS 2015).

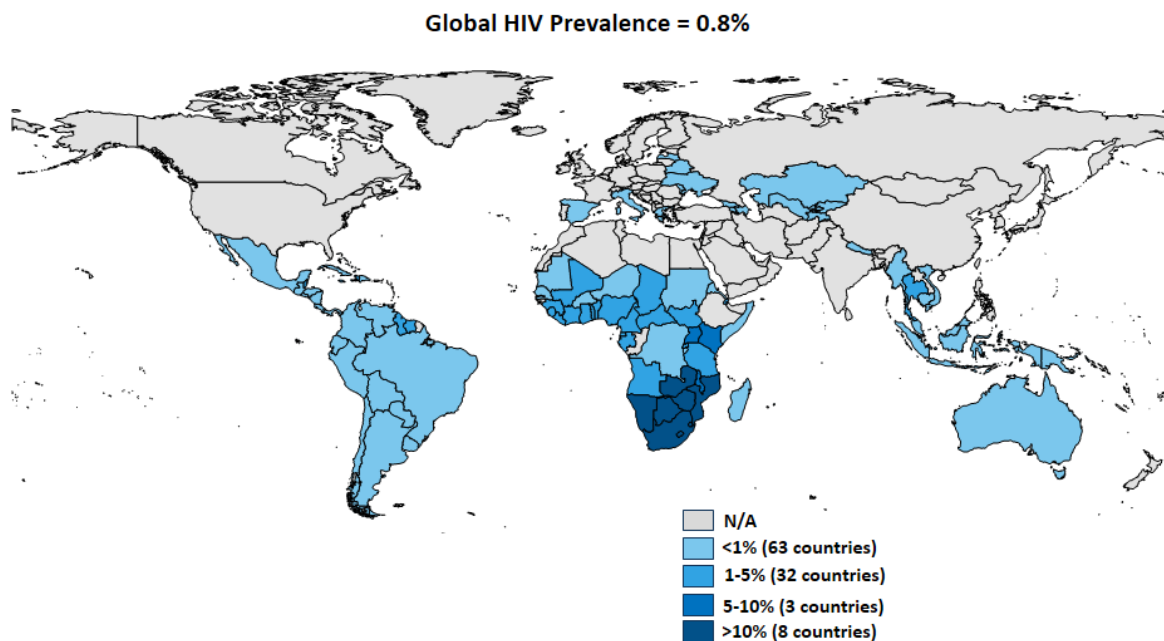
McKeague, Eisen, Mullins, Guéye-NDiaye, Mboup & Kanki, 2003). HIV-2 is less pathogenic and mostly located in and limited to Western Africa (Abdool Karim & Abdool Karim, 2005:110). For more information about HIV-0, HIV-1 and HIV-2, cf. Goudsmit, 1997.

⁴ At least nine generic subtypes can be found under HIV-1. Subtype B – on which most vaccine-related research has focused – is the main type in the Americas, western Europe, Australia and Japan (WHO, 2008), and accounted for about 3% of infections worldwide in 2005 (Abdool Karim & Abdool Karim, 2005:104).

⁵ Subtype C is the main type in Southern and Eastern Africa, India, Nepal, and parts of China (Goudsmit, 1997).

Figure 1

Adult HIV Prevalence, 2015



NOTES: Data are estimates. Prevalence includes adults ages 15-49.

SOURCES: Kaiser Family Foundation, based on UNAIDS, AIDSinfo, Accessed June 2016



Figure 2.1: Adult (ages 15 - 49) HIV prevalence 2015

Kaiser Family Foundation, based on UNAIDS, AIDSinfo, Accessed June 2016

<http://kff.org/global-health-policy/fact-sheet/the-global-hivaids-epidemic/>

Estimates suggest that about 6.7 million South Africans of which 6.5 million are adults (older than 15 years) were living with HIV in 2015 (UNAIDS, n.d.). Furthermore, a number of other illnesses co-infect with HIV, e.g., 70% of tuberculosis (TB) cases coincide with HIV-infection. Often when TB is reported as cause of death the relation this has to HIV/AIDS is obscured (Stine, 2012:318), which suggests that the number of deaths causally linked to HIV and AIDS could be significantly higher than is officially reported. The dominance of the virus varies depending on geographic area, ethnicity, age and gender.

2.2.2 HIV/AIDS in the Western Cape

Regarding the spread of the virus throughout the South African provinces, the latest data on which estimates are based is published in the *South African national HIV prevalence, incidence and behaviour survey* (Shisana, Rehle, Simbayi, Zuma, Jooste, Zungu, Labadarios, Onoya et al., 2014:xxiv) and reflect statistical information on data collected in 2012. As seen in table 2.1 below, KwaZulu-Natal has the highest number of inhabitants living with HIV, namely 16.9% of the population in the region. The Western Cape, the region in which this study is situated, has the lowest percentage of PLHIV.

Table 2.1: Overall HIV prevalence by province, South Africa 2012

Province	%
Western Cape	5.0
Eastern Cape	11.6
Northern Cape	7.4
Free State	14.0
KwaZulu-Natal	16.9
North West	13.3
Gauteng	12.4
Mpumalanga	14.1
Limpopo	9.2

Adapted from Shisana et al., 2014:37

Although in comparison to infections across the entire country the Western Cape has the lowest number of PLHIV, the increase of this number between 2005 and 2012 is bigger than that of the other provinces. Table 2.2 overleaf takes the provincial data from the last three *HIV prevalence, incidence and behaviour surveys* (2005, 2008 and 2012 in Shisana et al., 2014) in order to compare the number of PLHIV in those years. Here, the number of infections among adults aged 15 to 49 in the Western Cape more than doubled overall from 3.2% in 2005 to 7.8% of the regional population in 2012. Even though the percentage of infected persons remains the lowest of all the South African provinces, HIV still is the most common disease in the Western Cape. Although it does not single-handedly account for the majority of deaths (except for children and women aged 15 - 49), it is widely assumed to be the most pressing health crisis facing the province (Abdullah, 2004:248).

Table 2.2: HIV prevalence by province among respondents aged 15 - 49, South Africa 2005, 2008 and 2012

Province	2005%	2008%	2012%
Western Cape	3.2	5.3	7.8
Eastern Cape	15.5	15.2	19.9
Northern Cape	9.0	9.0	11.9
Free State	19.2	18.5	20.4
KwaZulu-Natal	21.9	25.8	27.9
North West	18.0	17.7	20.3
Gauteng	15.8	15.2	17.8
Mpumalanga	23.1	23.1	21.8
Limpopo	11.0	13.7	13.9
South Africa	16.2	16.9	18.8

Adapted from Shisana et al., 2014:46

2.3 ANTIRETROVIRAL TREATMENT IN SOUTH AFRICA

In order to address this national health problem, the local government prioritised the provision of ARV treatment to the masses. In April 2002, the Cabinet (Statement on Cabinet meeting, 2002, cited in Simelela & Venter, 2014:250) released a statement in which local government acknowledged a commitment to the “HIV/AIDS and [(sexually transmitted infection)] STI Strategic Plan for South Africa, 2000-2005” and appealed to the National Department of Health (NDoH) to start planning the commencement of an ART rollout plan. At the end of 2003, Cabinet (Statement of Cabinet on a Plan for Comprehensive Treatment and Care for HIV and AIDS in South Africa, 2003, cited in Simelela & Venter, 2014:250) approved the NDoH’s ART rollout plan after which ART was introduced countrywide in 2004 (Simelela & Venter, 2014:250) at which time the Western Cape also succeeded in providing ART to its inhabitants (Abdullah, 2004:246). This was the start of the largest ART initiative internationally (Floyd & Akpan, 2014; Shisana et al., 2014:112). Despite the implementation of ART in state health care, access to necessary medication has been said to lack progress, and the “roll-out of ARV’s in South Africa [was judged to be] painfully slow” (Hodgson, 2006).

Initially, out of the 840 000 people requiring ART, it was estimated that 200 000 would have had access by the end of 2005. Although it is a small number, it was an increase on the

estimated 104 000 receiving treatment by September 2004 (Hodgson, 2006). Table 2.3 provides more recent numbers regarding ART exposure⁶ by looking at South Africans living with HIV categorised according to sex, age, race, and locality type (Shisana et al., 2014:57). This table summarises the estimated number of PLHIV, the estimated number of people on ART, and then the proportion of PLHIV on ART⁷ at the time of the survey.

The statistics here show that a bigger percentage of females (34.7%) versus males (25.7%) are on ART. Further, 29.8% of PLHIV between the ages of 15 and 49 are on ART. It is also interesting to compare the urban and rural locality types where the figures indicate that in both formal and informal⁸ rural settlement areas more PLHIV are on ART than in the urban settlement areas. PLHIV who are also on ART who live in formal urban settlement areas (28.3% of the total infected) do not show a significant difference from those in formal rural residences (28.7% of the total infected); however, there are considerably less PLHIV who are on ART in informal urban settlement areas (27.4% of the total infected) in comparison to those in informal rural settlement areas (35.3% of the total infected). The reason for this is speculated to be due to the low socio-economic status of the people inhabiting these areas and the urban community being more destitute than in the rural areas where the community is probably more close-knit (Shisana et al., 2014:110).

⁶ Here, the term “exposure” refers to the introduction of the possibility of ART to individuals who test positive for HIV during which they are informed about ART as well as the national ART eligibility criteria.

⁷ It is important to state that the proportions of PLHIV should not be directly compared to the estimated number of HIV positive people on ART as not all PLHIV are eligible for ART. The latter only includes people who meet the requirements as set out in the national ART eligibility criteria (Shisana et al., 2014:112). Typically, ART only commences when (i) the CD4 cell count (clinically determined) is below 200, (ii) it is clear that patients are completely committed to follow the strict medication regimen (for the rest of their lives), (iii) patients show understanding of the possible side-effects, and (iv) patients will commit to regular follow-up visits in which viral load and CD4 count will be monitored (Van Dyk, 2008:106).

⁸ “Informal settlements”, or housing created in urban, peri-urban or rural locations without official permission differ to formal housing not only in its nature, but socio-economically as these (generally overpopulated) residences are situated in inappropriate areas and lack access to health, educational and basic services, as well as general infrastructure (National Department of Human Settlements, 2016).

Table 2.3: Exposure to ART among PLHIV by sex, age, race and locality type, South Africa 2012

Variable	Estimated number of PLHIV (n)	Estimated number of people on ART (n)	Proportion of PLHIV on ART (%)
Sex:			
Male	2,531,000	651,000	25.7 [21.2–30.8]
Female	3,873,000	1,344,000	34.7 [31.4–38.2]
Age group (years):			
0-14	369,000	166,000	45.1 [33.9–56.9]
15-24	720,000	103,000	14.3 [10.0–20.0]
25-49	4,706,000	1,466,000	31.2 [27.4–35.2]
50+	610,000	260,000	42.7 [35.7–50.0]
15 - 49	5,426,000	1,569,000	28.9 [25.6–32.5]
Race:			
Black African	6,232,000	1,924,000	30.9 [27.7–34.3]
Other	172,000	71,000	41.3 [30.0–53.7]
Locality Type:			
Urban formal	2,558,000	724,000	28.3 [22.5–39.4]
Urban informal	851,000	233,000	27.4 [23.0–32.4]
Rural informal	2,727,000	963,000	35.3 [31.3–39.5]
Rural formal	286,000	82,000	28.7 [20.1–39.2]
Total	6,422,000	2,002,000	31.2 [28.1–34.5]

Adapted from Shisana et al., 2014:57

Although the initial implementation of the ART programme could have been categorised as slow and ineffective, the general exposure of PLHIV to ART programmes has grown. The immediate benefits of this initiative can already be seen in the significant decrease of HIV/AIDS related deaths in the country (Shisana et al., 2014:112). Further, the survey shows that ART exposure among PLHIV nearly doubled between 2008 (16.6%) and 2012 (31.2%).

2.4 VOLUNTARY COUNSELLING AND TESTING

VCT have provided millions with the simple service of discovering their HIV status. The World Health Organization (WHO) estimated that 118 million people in 124 low and middle income countries underwent this service in 2012 (WHO, n.d.). Lindegger and Crewe (1997:272) list five priorities concerning HIV/AIDS counselling as set out in the national AIDS plan in the AIDS Bulletin, July 1994. Pre- and post-test counselling must accordingly be (i) accessible to all South Africans by providing a (ii) wide-ranging, skilled network of counsellors in the medical sector and community, in facilitating counselling that is (iii) sensitive to cultural diversity, (iv) based on confidentiality, and (v) integrated into additional services.

The purpose of VCT is not merely the identification of HIV status; it is also to provide information regarding prevention and limiting transmission of the virus (Regensberg, Dunn & Maharaj, 2014:7). For individuals who test positive; information is given about the virus itself as well as possible treatment options. They can then seek support, care and treatment, or mothers can get information regarding prevention of mother to child transmission (PMTCT) protocol (Musingafi, Rugonye & Zebron, 2012:72). According to the Centers for Disease Control and Prevention (CDC), the optimal way to decrease new HIV infections is by increasing awareness among infected individuals (Rassool, 2004:458).

It has also been found that this service can positively affect individuals who test negative, as knowledge of one's negative status – whether through motivation to remain negative, or education about infection given through counselling – can influence behaviour change in potentially risky situations. Studies have found that VCT is associated with lower HIV incidence (Rosenberg, Westreich, Bärnighausen, Miller, Behets, Maman, Newell & Pettifor, 2013). In her study of VCT services in Namibia, Iafigliola-Kriner (2006:16) found that “there appears to be a decrease in risky behaviour in the majority of individuals attending VCT services.”

Traditionally, the counselling in VCT was carried out by professional psychologists and psychiatrists, together with increasing numbers of social and other health care workers (Sherr, 1999:53). As the epidemic grew, however, so did the requirement of counsellors in adequate numbers, which led to the training of lay counsellors. In reporting on the success of adherence to ART through VCT in impoverished areas of South Africa, Abdool Karim and Abdool

Karim (2005:447) find that community involvement as well as the recruitment and training of lay counsellors is crucial.

2.4.1 The importance of counselling as part of HIV-testing

Counselling is suggested to be a crucial factor in any attempt at the prevention of HIV infection as well as caring for the infected (Carballo, 1988:77). Sherr (1999:39) sees HIV counselling as an answer to the “need for information transfer, behaviour change, and as a possible solution to action in the face of ignorance and uncertainty.” (Cf. McLeod, 2003 for background on counselling in general). Carballo (1988:78-79) identifies four basic needs that HIV counselling should specifically address. As a positive HIV status can be accompanied with a variety of anxiety and stress related issues, counselling (i) provides psychological and social support for infected individuals, (ii) attempts to encourage the necessary and practicable behaviour changes in infected individuals, (iii) ensures sustained integration of HIV infected individuals into their communities on an economic, intellectual and social level, and finally (iv) aims to reduce psychological and medical ailments that infected individuals might present.

Johnson (2000:2-3, cited in Van Dyk, 2008:219-220) identifies compassion to be the most important characteristic of an HIV/AIDS counsellor. This compassion should be manifested in the person’s willingness to share another person’s experience in living within the limitations of a life-threatening disease. Johnson elaborates by saying that the aim of the counselling process for HIV positive individuals is to shift the focus from the limitations that come with the virus, to the quality of life beyond it. This can be done by helping with the management of current and potential future problems that may arise.

2.4.2 Counsellor training

Since the beginning of the attempt to confront the spread of HIV, ways in which to prevent the transmission thereof developed. This led to an industry aimed specifically at training health care workers to facilitate pre- and post-test counselling in VCT (Sherr, 1999:56). This industry takes the form of training organisations and programmes which came to life as a result of a national health initiative started in the late 1980s (Van Houten, 2007:43). One such organisation, the Western Cape AIDS Training Information and Counselling Centre (ATICC), launched in 1989, is one of 24 centres provided by the NDoH between 1989 and 1995 (Western Cape Government, 2016a).

The vision of the ATICC is to play a leading role in preventing the spread of HIV. Their mission includes the prevention of HIV transmission and the provision of support for PLHIV. In order to realise this mission, the ATICC's goal is to train health care workers, provide the general public with necessary information and resources, and offer ethical VCT to all who require it (Western Cape Government, 2016a).

In August 1989, the ATICC hosted their first HIV/AIDS training course. It was attended by 36 people. Since its inauguration until 2004, ATICC trained 14 648 people, ranging from HCPs, counsellors, educators, human resource staff, politicians and administrators (Van Houten, 2007:44). The courses provided by ATICC include general HIV/AIDS information courses, counselling and master counselling, medical management, follow-up training for those already trained, master training, and clinic based counselling courses. ATICC also made a substantial contribution with initiating new programmes like the VCT programme with which this study is concerned (Van Houten, 2007:44).

2.4.3 Structure of VCT

Managing and counselling HIV positive patients from a positive result through to possible ART is not the only responsibility of the counsellor. On a day to day basis the majority of HIV counsellors' time is spent on administering VCT sessions. In order to do this, they need to be trained to facilitate pre- and post-test counselling sessions. VCT can be seen as a "critical gateway to services" (WHO, 2011:76) and is therefore an important factor in increasing access to treatment and prevention of infection. The compulsory structure of a typical VCT session must involve pre-test counselling, the execution of the test, followed by post-test counselling.

2.4.3.1 Pre-test counselling

Harris (1988:82) classifies pre-test counselling as "the first level of screening" as it enables the counsellor to evaluate the patient in terms of risk and psychological status. Logistically, it is carried out in a private area and is usually done by a nurse or trained lay counsellor (Western Cape Government, 2016b). Ideally counselling should be conducted in the mother tongue of the patient, and informed consent to the test should then be given in written form (Regensberg et al., 2014:7). When a person is legally entitled to provide consent on behalf of someone else (i.e. a parent or guardian of a child below the age of 12), it is called "[p]roxy consent" (Western Cape Government, 2016b).

The aim of pre-test counselling is to ensure that the patient has adequate information and fully understands the nature of the test that is to follow in order to make an informed decision in giving consent (Western Cape Government, 2016b), which includes knowledge that HIV infection, rather than AIDS will be tested (Corbitt, 1999:33). Van Dyk (2008:254) summarises additional content that needs to be covered in this session as the following: test procedure, the role (if necessary) of a confirmatory test, immediate results (with rapid testing), the difference between being seropositive (HIV positive) and having AIDS, the presence of HIV antibodies in the blood, the meaning (and implications) of testing positive or negative, the ‘window period’ concept, and the reliability of the test procedures. Other important issues that Regensberg et al. (2014:9) include as themes for the VCT session are ways in which HIV is transmitted, ways to reduce risk of transmission (and protect sexual partners), the individual’s social support, as well as confidentiality in testing. Finally, Tallis (1994:1) adds the importance of exploring the individual’s general understanding of the virus.

On the issue of the possible implications of the test result, Van Dyk (2008:255) stresses the importance of talking about possible advantages and disadvantages of taking the test, together with the personal implications of the possible results. Since individuals are likely to be apprehensive in this context, she suggests that the advantages of taking the test should be emphasised. These advantages include reduced stress regarding uncertainty about one’s status; future planning that becomes possible with the certainty of a result; and the confirmation of symptoms that could be treated correctly.

Musingafi et al. (2012:72) focus on the responsibilities of nurses and lay counsellors to strive to achieve mutual understanding with the individual in order for the patient to acquire as much information as possible. Further, the information regarding the illness presented by the counsellor must be correct and help individuals with their decision-making process, as well as reducing their infection or transmission risk. Finally, they emphasise the responsibility of the counsellor to assess the patient’s ability to deal with having HIV/AIDS in the family, and to place the person in a risk group category which will advise on treatment options.

2.4.3.2 Test

After the necessary information has been conveyed, an informed choice has been made on the side of the individual, and written consent has been given, the HIV test may be administered. The test is done on a blood sample collected through a finger prick and is done by the same

counsellor. All the tests that are currently used at the day care clinic facilities are rapid tests, which show the result within 20 minutes.

The basic HIV test developed in the late 1990s known as the ELISA (Enzyme-linked immunosorbent assay - found in a laboratory or ‘rapid’ form) test, is an antibody test which has greatly facilitated HIV testing services to large numbers of people (WHO, n.d.). It is routinely used to screen the blood not to detect whether the actual virus is present in the blood, but whether antibodies to the virus have been formed (in response to the virus being present in the blood) by the individual’s immune cells (Musingafi et al., 2012:124). Although this test is quite sensitive, a positive result should always be confirmed with a laboratory ELISA test which is more thorough. It can be administered outside a laboratory and it is easy to use, inexpensive and reliable if used correctly (Van Dyk, 2008:86). The WHO reports on innovative ways in which services have been delivered and implemented throughout the world. This includes home testing, mobile and outreach testing in communities, so-called “moonlight” testing after hours in areas known to have a higher risk, as well as in schools, at the workplace, religious facilities, and transport hubs (WHO, n.d.).

2.4.3.3 Post-test counselling

The post-test counselling session is centred around the announcement of the test results. Like the pre-test counselling, this is also confidential and administered only after consent has been given (Musingafi et al., 2012:125; Western Cape Government, 2016b). Counsellors are legally prohibited from giving any test result without permission from the individual. During the post-test, the counsellor’s aim is to assist and guide individuals receiving their test results (Musingafi et al., 2012:72).

In the case of a negative result, the topics covered in post-test counselling include the dangers of behaving in a sexually risky manner, as well as ways in which to practice safer sex by, for example, using condoms (Western Cape Government, 2016b). In the case of a positive result, the counsellor should be aware and sensitive towards the emotional reaction of the individual which may include “anger, aggression, shock, dismay, anxiety, guilt, bargaining or acceptance” (Musingafi et al., 2012:72). In his research, Kalichman (1998:149) finds that receiving a positive result in HIV testing can be so traumatic for patients that they find it difficult to “retain information provided to them during post-test counselling,” which is why the main aim of the counselling session here should be to assist the individual with the

process of internalising and coping with the news (Western Cape Government, 2016b). Additionally, topics such as diet and nutrition, type of behaviour to minimise transmission, as well as the importance of on-going counselling, should be discussed (Musingafi et al., 2012:72).

2.5 CHALLENGES FACING THE SOUTH AFRICAN HEALTH CARE SYSTEM

In order to understand the conditions in which VCT services are provided, it is necessary to examine the state of the national health care system. Coovadia, Jewkes, Barron, Sanders and McIntyre (2009) published a review on the profound effect that South Africa's history of colonialist suppression and more recent governmental oppression has had on its present day health services and policies. Such histories also affect the health of people in the country. Coovadia et al. (2009) go on to consider current health challenges facing the post-apartheid government.

After the abolishment of apartheid, the South African government attempted to correct the imbalances that discrimination had created between the various ethnic groups. In order to bridge this gap (which after 22 years remains a challenge), the aim is to provide all South Africans (regardless of race, socio-economic status, cultural or linguistic background) equal access to and reception of health care services. The public health system – on which an estimated 64% of the population solely relies (Coovadia et al., 2009:827) – was transformed into an “integrated, comprehensive national service, driven by the need to redress historical inequities and to provide essential health care to disadvantaged (especially rural) people” (Coovadia et al., 2009:828). According to the *Patients' Rights Charter* (HPCSA, 2008:1-2), every South African citizen has the right to access timely emergency care, medical treatment and rehabilitation, provision for special needs (which include PLHIV), non-biased counselling, palliative care, health care staff providing service with a positive, courteous attitude, as well as health information in the language understood by the patient.

Additionally, phenomena like poverty and unemployment in South Africa are associated more with rural rather than metropolitan areas (Pauw, 2005:1). These in fact are often interpreted as a cause of urbanisation. The vast majority of health care services (clinics, community health centres, regional and tertiary hospitals) in the Western Cape are in the urban areas of the Cape Peninsula. This explains why people in need of medical treatment who reside in rural areas

often find it difficult to access health care services. Lack of infrastructure and medical staff at these facilities is widely reported. Some rural towns (one of which is featured in this study) do not have hospitals, meaning that many people need to travel to neighbouring towns in order to receive even primary medical care.

The challenges remaining in developing and maintaining quality in national and provincial health care service include among others infrastructure, human resources, management and leadership (Coovadia et al., 2009; Abdullah, 2004). An important challenge in HIV care is the accommodation of a linguistically diverse community. Since language is an important, in fact critical element in HIV care, studying the usage and accommodation of various languages and language varieties is important because it supports the ideal of providing access to all patients.

2.6 LINGUISTIC DIVERSITY AND NATIONAL LANGUAGE POLICY OF SOUTH AFRICA

Although the issue of multilingualism, and the South African multilingual landscape, falls outside the scope of this study and would require a different theoretical angle, touching upon the national and regional linguistic diversity is important for providing a foundation in which this study fits. The data selected for purposes of analysis in this study focuses on one of the official South African languages only. Rural clinics in South Africa often exhibit communicative difficulties. In rural areas of the Eastern Cape patients are mostly monolingual L1 isiXhosa speakers; additionally the distribution of English L2 is limited and rarely suited to sophisticated medical communication. Contrastively, the dominant language of rural Western Cape is Afrikaans. Counsellors typically have the same language repertoire as the majority of the patients they see. Even so, the mobility of e.g. the isiXhosa population and foreign nationals adds to the linguistic diversity of the area and so also to the communicative challenges. Accurately reflecting South Africa's vast linguistic diversity, the Constitution of the Republic of South Africa Act (1996:10) has recognised 11 official languages. These are the languages spoken by the majority of the South African population: the percentages of speakers in relation to the total population are given in table 2.4 overleaf. Countrywide, according to the latest national census of 2011, the language most spoken as L1 is isiZulu (22.7%), followed by isiXhosa (16%) and Afrikaans (13.5%). Although English is only spoken as an L1 by 9.6%, it fulfils the general role of *lingua franca* as it is generally used in

business and government and it is an L2 for most South Africans regardless of their different L1s.

Table 2.4: Speakers of South African Languages, 2011

Language	Number of L1 speakers	% of total
Afrikaans	6 855 082	13.5%
English	4 892 623	9.6%
isiNdebele	1 090 223	2.1%
isiXhosa	8 154 258	16%
isiZulu	11 587 374	22.7%
Sepedi	4 618 576	9.1%
Sesotho	3 849 563	7.6%
Setswana	4 067 248	8%
Sign language	234 655	0.5%
Siswati	1 297 046	2.5%
Tshivenda	1 209 388	2.4%
Xitsonga	2 277 148	4.5%
Other	828 258	1.6%
Total	50 961 443	100%

Census 2011, adapted from <http://www.southafrica.info/about/people/language.htm>

When discussing the South African national language policy, Anthonissen (2010:114) mentions provisions made for implementing an additional structure aimed at expanding and building resources and general usage of indigenous languages that did not previously receive this kind of interest. The Pan South African Language Board (PanSALB) was established with such promotion of multilingualism in mind. Webb (2002:290) describes this Board as “a constitutionally prescribed language management body, envisaged to be independent of the government ... and tasked to act as watchdog on all language policy and planning issues in the country.”

According to the PanSALB Amendment Act of 1999, the Board was created to develop the 11 official languages in accordance with the provisions of the national language policy (PanSALB, n.d.). It is clear from the mission and vision statement of the PanSALB that it is sensitive to the country’s linguistic diversity, supporting equal rights for each language as it supports an ideal according to which individuals should be free to conduct their lives, also their public lives, in the language best suited to their wellbeing. In accordance with Beukes (2009:50) who concluded that this Board’s performance record reflects a limited understanding of significant linguistic problems that exist within the South African

educational system, Anthonissen (2010:115) is sceptical as to the extent to which these intentions have been achieved in practical application.

Multilingual communication has steadily been increasing not only on an international level, but also an intranational level as a result of migration worldwide (House & Rehbein, 2004:1). Due to global patterns of mobility, public facilities such as hospitals in which people are required to function and interact efficiently on a day-to-day basis, become spaces where speakers of different languages meet. This has brought about a growing need for multilingual accommodation (House & Rehbein, 2004:5). The recognised basic human right of people to consult with, and be diagnosed and treated by an HCP in their L1 has implications for language planning in health care. Concern about such rights has led to the development of solutions in the form of interpreting in health care communication.

Although PanSALB is not the only driver of language policy in South Africa, language planning and policy issues in the country persist. Although this study focuses on Afrikaans counselling sessions only, the multilingual nature of health care in South Africa cannot be overlooked. In short, the promotion and development of all South African languages and provision of improved translation and interpreting services is sure to promote health care provision in general as well as in HIV counselling. To illustrate, the HIV clinics have no official provision of translation and interpreting services. Counsellors report that when communicative difficulties arise between HCPs and patients, other staff members (nurses, cleaners and in some cases, security personnel) are called in to assist as interpreters. In the Western Cape such staff members are often L1 speakers of isiXhosa who are adequately proficient in the *lingua franca*. This is a great help and certainly better than having no interpreting support at all, but not without risk as it promotes the misconception that anyone who speaks two languages has the ability to serve as interpreter between those languages⁹.

One of the clinics in this study has a receptionist who can speak basic Shona. She is standardly asked to interpret when Zimbabwean Shona L1 speakers with low English proficiency need to be counselled. When she is absent, Shona-speaking patients cannot be tested for HIV as they cannot be linguistically accommodated in the obligatory pre-test

⁹ For literature on the importance and benefits of translation of interpretation within health care communication, whether it is a professional or ad hoc interpreter, see Angelelli, 2004; Jacobs, Chen, Karliner, Agger-Gupta & Mutha, 2006; Meeuwesen, Twilt, ten Thije & Harmsen, 2010; Rosenberg, Leanza & Seller, 2007; Baraldi & Gavioli, 2007; Leanza, Boiven & Rosenberg, 2010; Kazzi & Cooper, 2003; Killian, Swartz, & Joska, 2010; Deumert, 2010; Bührig & Meyer, 2004; Hsieh, 2005, 2007, 2010, Watermeyer, 2011.

counselling. Ad hoc interpreters were present in two consultation sessions in the larger dataset collected for this study. The data as well as metadata have been documented and saved for follow-up work where the role of interpreters, their training and availability should be investigated.

2.7 SITUATIONAL CONTEXT IN THE WESTERN CAPE

In order to properly orientate this study, it is necessary to narrow the focus from South Africa to the Western Cape Province. This will be done by firstly providing background information on the racial distribution of its population, as well as the geographic setting of the district within the Western Cape in which this study is based. Secondly, the languages spoken by this population will be regarded.

2.7.1 Population and geography

According to the 2011 census (Statistics South Africa, 2012b:15), 10.6% out of a total population of 51.8 million in South Africa reside in the Western Cape. Table 2.5 overleaf shows the distribution of population groups per racial classification¹⁰ in the Western Cape. The Western Cape is the only South African province where the majority group is “coloured” as contrasted to black African inhabitants who are the majority in all other regions. This is informative not only on patterns of infection and provision of health care; it also correlates with a different region-specific distribution of national languages (as discussed in 2.6. above).

¹⁰ The reason for providing a racial breakdown here relates to the fact that a former dispensation worked with such categories. To this day (22 years post-Apartheid) people still live in communities established along racial lines and it has been established that certain communities are much more vulnerable to infection than others. This can be associated with socio-economic circumstances and related to social vulnerability. The post-1994 government has maintained working with racial classification as a means of monitoring the progress of repair in areas most severely affected and still suffering from past neglect.

Table 2.5: Distribution of population groups per racial classification in the Western Cape

Population group: Western Cape	Number of people	Percentage
Black African	1 912 547	32.8
Coloured	2 840 404	48.8
Indian / Asian	60 761	1.0
White	915 053	15.7
Other	93 969	1.6
Total	5 822 734	100.00

Adapted from Statistics South Africa, 2012b:21

In terms of geographic properties, the Western Cape has been divided into six municipal districts as set out by the Local Government Municipal Structures Act 1998. These districts (represented visually in figure 2.2 overleaf) are the City of Cape Town (the metropolitan municipality), together with five district municipalities: the West Coast, Cape Winelands (Boland), Overberg, Central Karoo and Eden. The two towns in which the data for this study were collected are in the Cape Winelands district, falling under the Breedevalley and Witzenberg municipalities. The majority of the Western Cape population inhabits the metropolitan municipality, the City of Cape Town (The Local Government Handbook, n.d.), whereas the rest of the population live in rural towns throughout the district municipalities. For a population distribution within these municipalities, see figure 2.3.



Figure 2.2: Municipal districts of the Western Cape

Source: <http://www.cohsasa.co.za/institution-district/cwdm>

The majority of people living in the rural areas – such as in the case of this study – are employed within the agricultural economy, whether as seasonal or factory workers. The United Nations has estimated that about seven million agricultural workers within the 25 African countries that are worst affected by HIV/AIDS have died since 1985, and it is projected that another 10 million will die by 2020 (Stine, 2012:316). In South Africa 30% to 45% of agricultural workers are HIV positive (Stine, 2014:352). These statistics and the growing prevalence of HIV/AIDS emphasise the importance of providing ART as well as improving general access to health care facilities.

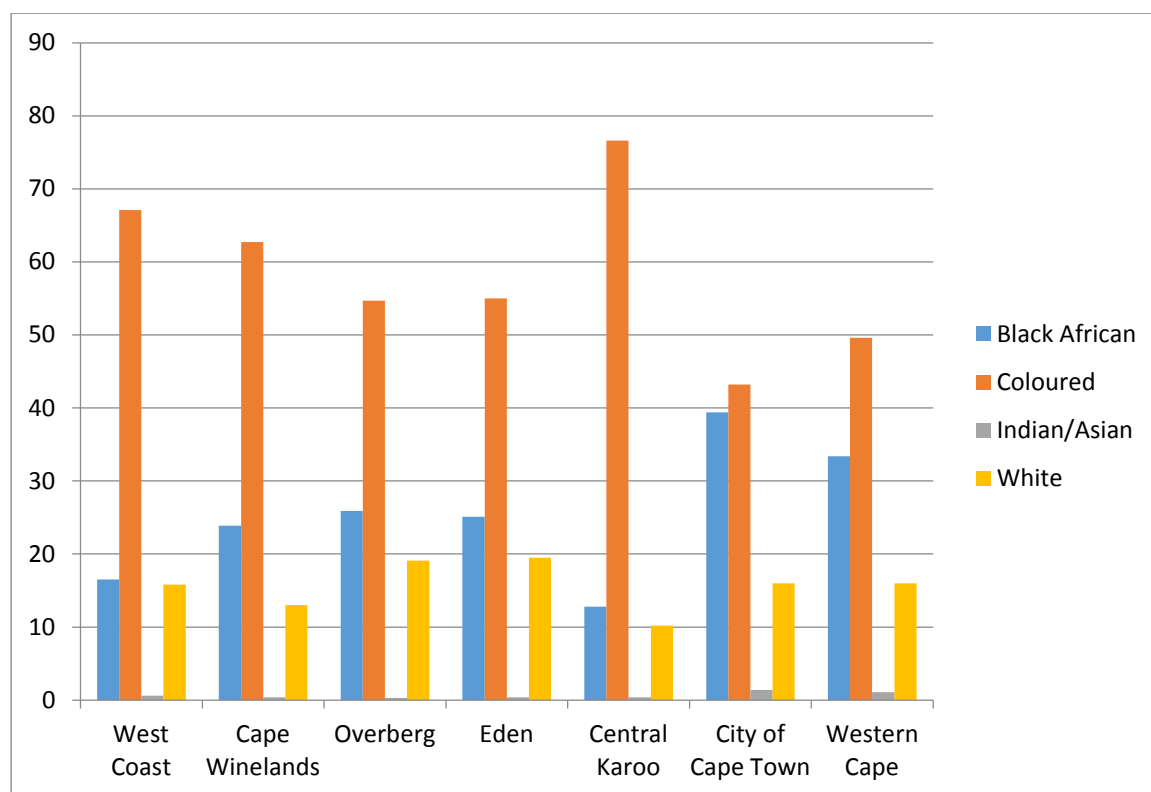


Figure 2.3: Population by district municipality and racial group in the Western Cape

Adapted from Statistics South Africa (2012a:11).

As is clear in the representation of the population distribution within district municipalities above, the majority of inhabitants in each of the municipal districts in the Western Cape is coloured. As mentioned previously, these statistics make the Western Cape unique from other South African provinces. This distinction in racial distribution also then holds corresponding linguistic diversity for this province.

2.7.2 Linguistic diversity

Different languages are predominant in different areas of the country. Although isiZulu is known to be the most spoken language in the country, the distribution of its speakers differs from province to province. For example, the provinces in which isiZulu is most widely distributed as L1 are KwaZulu-Natal (77.8%), Mpumalanga (24.1%) and the Gauteng province (19.8%). In the Western Cape, however, isiZulu is spoken by 0.4% of the population (Statistics South Africa, 2012b:25). Depending on the province, the chosen languages for communication in public spaces are determined by which ones are predominant in a given region. According to the 2011 national census (Statistics South Africa, 2012b:25) the three

languages that will most often be considered for public use, also in the HIV clinics, in the Western Cape, would be Afrikaans (49.7%), isiXhosa (24.7%), and English (20.3%). The three official languages in the province are thus Afrikaans, English and isiXhosa (Province of Western Cape, 1998).

As in the case of most of the other provinces, English - despite its low percentage of L1 speakers - is often chosen as *lingua franca* since it is spoken as an L2 by most Afrikaans and isiXhosa L1 speakers in the Western Cape. Further, English is known as the language of learning and prestige, and is also perceived as the language of social and employment opportunities (Anthonissen, 2010:113). Despite the status of Afrikaans as a *lingua franca* throughout the Western Cape, Anthonissen (2008) reports on the tendency among middle class coloured communities historically identified as Afrikaans L1 to select English as home language and language of the workplace.

2.8 CHALLENGES IN HEALTH CARE COMMUNICATION

The South African Language Policy (South African Department of Arts and Culture, 2002) secures equal language rights for speakers of all official languages. This includes the right of individuals to communicate in the languages of their choice, also in public service domains. As stated previously, the *Patients' Rights Charter* (2008) affords patients the right to be informed about their illness as well as treatment options in their mother tongue. On a provincial level, the *Western Cape Provincial Languages Act* (Province of Western Cape, 1998:5) states that any citizen of the Western Cape may “be served in any of the three official languages (Afrikaans, English, isiXhosa) at or by any institution of the Provincial Government.”

“Successful treatment of HIV-related illnesses, and particularly gaining desirable results from ARV treatment, appears to be dependent on successful communication between clinic staff and patients” (Anthonissen & Meyer, 2008:3). For successful treatment of PLHIV that will increase their quality of life, special attention needs to be given to distributing information on HIV. The 2012 survey on national HIV prevalence, incidence and behaviour (Shisana et al., 2014:93) lists 26.8% of the participants (15 years and older) as knowledgeable about the sexual transmission as well as prevention of the virus. This is the information that is conveyed on a one-on-one level during the VCT counselling sessions analysed in this study. Successful communication between counsellors and patients in this context is therefore crucial for

patients' understanding of HIV, empowering the community with knowledge, which could in turn contribute to preventing transmission rather than merely treating the symptoms.

2.8.1 Misunderstandings and linguistic barriers

Roberts, Moss, Wass, Sarangi and Jones (2005:468) define misunderstandings as occasions where (i) the lack of understanding between two participants interrupts the flow of the communication, (ii) an initial understanding proves later in the conversation to have been illusory, or (iii) instances where indirect social inconsistencies cause conversational discomfort that impedes the natural progress of interaction. Here they refer to what Schegloff (1987) calls “trouble” in interaction: when the manner in which the interaction did not go smoothly cannot necessarily be identified explicitly, but the participants have not been able to express their intentions clearly.

While this type of “trouble” in interaction can primarily be connected with linguistic barriers in the form of interactants not sharing an L1, these types of misunderstandings – as is seen in this study – are also found between interactants who share the same linguistic repertoire. Even when participants share a *lingua franca* on a proficient level, elements such as pronunciation, intonation and differences in syntactical structure can have an effect on understanding (Roberts et al., 2005:474). South Africa's rich linguistic diversity assures a range of accents and dialects as a regular part of everyday interaction. So, for example, one of the counsellors in this study is an L1 isiXhosa speaker who counsels the L1 Afrikaans patients in her L3, which is a relatively accented version of Afrikaans.

In addition to the conversational features of the spoken text, this study pays special attention to the rigid structure of the pre-test HIV counselling session as a conversation type (cf. chapter five for an in-depth analysis). Rehbein (1994:83) finds that many of the communicative problems that are encountered in social groups and societies do not just lie in “superficial misunderstandings but in far-reaching communicative structures”. It can be said that in the same way as an unshared linguistic repertoire will provide obstacles that threaten communicative success, the strict protocol to which counsellors adhere in these conversations also contributes to “trouble” in communication. The almost checklist-type manner in which counsellors conduct the conversation brings about unnatural and inflexible conversational flow. The structural boundaries that the counsellor sets through this approach therefore do not provide the patient with natural opportunities to raise uncertainties or questions. This often

leads to patients applying the principle of ‘let it pass’ (House, 2003), i.e. of not addressing matters they do not follow, letting them pass in the hope that the rest of the conversation will bring more clarity.

The Deumert (2010) study focuses on linguistic barriers between English/Afrikaans-speaking HCPs and isiXhosa speaking patients. She finds the language discordance often brings about “unproductive patient-provider interactions” (Deumert, 2010:53). Byrne and Long (1976:63) defines this kind of consultation in which the needs of neither the doctor nor the patient have been met, as “dysfunctional consultations”. Deumert (2010) finds that these linguistic barriers are fixed in the structural foundation of public health care and threaten the post-apartheid ideal of providing equitable and efficient health care for all. Deumert (2010:54) lists ways in which language barriers in health care settings can cause misunderstanding which may limit accessibility and quality of health care. Again, although Deumert’s focus here is on linguistic barriers between English L1 or Afrikaans L1 HCPs and isiXhosa speaking patients, these unproductive patient-provider interactions – it is argued here – are also brought about through structural constraints on the conversation as a whole, even with shared linguistic repertoires. Three important consequences of misunderstanding that she lists are relevant to this study.

First Deumert (2010:54) finds that the presence of language barriers in health care communication can cause avoidance behaviour in that patients might shy away from situations in which they are required to communicate using a language with which they are not comfortable. Such behaviour diminishes the chances of early detection of illnesses since patients lack primary health care sources. Second, the quality of care can be jeopardised by linguistic misunderstandings in that this can lead to misdiagnosis and the consequent prescription and implementation of incorrect treatment regimes.

Third, when patients are not fully informed about their illness (or not given natural opportunities to voice their concerns or uncertainties), there is a real chance that their attitude towards adherence to medication will be affected. Although misunderstanding can be experienced by one party only, as where e.g. a patient does not follow the HCP, Roberts et al. (2005:469) hold that misunderstandings are “jointly produced”. They suggest that misunderstandings occur due to both participants’ struggle to negotiate and maintain comprehension.

In accordance with Deumert's (2010) findings, Anthonissen (2010:113), in her study on managing linguistic diversity in a South African HIV/AIDS day clinic, finds that despite the prevalence and growth of English as L1 and L2 in the region, Afrikaans is still widely encountered. Among doctors and staff at rural HIV-clinics in the Western Cape many give Afrikaans as their L1. Also, a high percentage of the patients who attend these clinics are Afrikaans L1 speakers. Anthonissen (2010:114) reports further that isiXhosa L1 speakers often choose to communicate in their third language (L3) (Afrikaans) rather than their L2 (English) in order to accommodate the HCP. She also attends to code-switching and its occurrence in different contexts (Anthonissen, 2010:118). In discussing language barriers experienced by isiXhosa speaking parents interacting on behalf of their children, Levin (2006:1078) finds that in some cases parents their own linguistic shortcomings for inadequate or unsuccessful communication instead of requesting an interpreting service.

Although correcting this linguistic imbalance is currently given high priority in state health care, it is still quite uncommon to find a doctor consulting in isiXhosa in HIV care (Anthonissen, 2010:114).¹¹ Throughout their experience consulting with patients, doctors have learnt some basic isiXhosa words to use during consultation, but these basic terms on their own are not sufficient for achieving the set communicative goals. Deumert (2010:56) provides an example of a doctor who knows the isiXhosa term for coughing to be *khohlela*. In the consultation, however, asking whether a patient is coughing is not enough. The doctor mentions that he cannot enquire about important detail necessary for proper diagnosis, e.g. whether the coughing is painful, or whether it is bloody. Without acquiring a verbal history of the illness, reaching a proper diagnosis is extremely difficult.

2.8.2 HCP concerns

Deumert (2010:58) notes an “awareness among [health care] providers that ‘yes’ is not always a sign of comprehension.” She recognised the awareness doctors have of patients being embarrassed about not following and therefore not signalling their difficulty with comprehension. Sensitivity to “facework” prohibits many HCPs from probing and then showing up limited language proficiency of the patients. In order to monitor the degree of a

¹¹Anthonissen's (2010) focus, as well as many others studying linguistic barriers in health care, is on doctor-patient communication where the majority of the formally trained doctors cannot speak isiXhosa. The focus of this study, however, is the interaction between HIV counsellors and patients. The counsellors who come from the local communities have a more diverse linguistic repertoire (cf. section 4.3.1 of this study for more information) and are mostly able to accommodate patients in their L1.

patient (as hearer) understanding throughout longer monologue-type sequences, HCPs must then interpret the signals provided by the patient as these signals provide feedback about the way in which a patient processes information that the counsellor has conveyed. Considering that one of the goals of the HCP within this discourse type is to ensure genuine understanding on the part of the patient, monitoring and interpreting these signals are crucial (Peräkylä, 1995:4). The importance of correctly interpreting hearer signals in HIV counselling context has been amply emphasised.

The counsellors who participated in this study confirmed the risk of patients misunderstanding much of the biomedical information regarding HIV/AIDS (together with additional information crucial for e.g. lowering the risk of infection, etc.), and of the rules of adherence to ART in the case of patients eligible for ART. The importance of compliance to a strict treatment regimen is well-known. Counsellors were concerned about how well the information they gave out was understood and taken to heart. For patients with low literacy levels (as were many attending the rural clinics) counsellors sometimes resort to drawing pictures to help patients understand various kinds of information, including e.g. which pills need to be taken at which times of the day.

2.9 CONCLUSION

Background information on the situational context in which this study is grounded has been provided in this chapter. The everyday challenges in the South African health care system could cause difficulty in the transfer of critical health care information during VCT. Not only do language barriers due to diverse linguistic repertoires of visitors to the clinics pose a challenge, but so do the structural constraints of the conversation that is dominated and led by the counsellor. In interviewing the HCPs at the clinics connected to this study, all the doctors and counsellors voiced concern as to problems brought about by linguistic diversity and misunderstanding in general. Patients have been found to be more likely to negatively evaluate first encounters where they experience alienation. This may lead to the transfer of such feelings to the health care system as a whole, resulting also in reluctance to return. This kind of situation, in Deumert's (2010:59) opinion, will also systematically marginalise patients from linguistic minority groups. In the case of this study, any patient regardless of her/his L1 may be alienated in such a way.

In order to avoid these undesirable consequences, the generic features and structure of pre-test VCT counselling has to be investigated in order to analyse and understand the way(s) in which this type of conversation threatens patient understanding. Successful communication is crucial for the distribution of knowledge that will bring about change in lifestyle and associated HIV infection rates of the most affected communities. To aid the process of identifying and investigating generic features of pre-test VCT counselling, existing literature has to be consulted while new insights are being developed. The following chapter reviews literature on the study of spoken language, the analysis thereof, as well as the kinds of nonverbal phenomena found in talk-in-interaction.

Chapter Three

LITERATURE REVIEW

3.1 INTRODUCTION

In order to provide the framework of received knowledge on which the analyses in this study have been based, this chapter provides an overview of existing literature covering four topics which are relevant to the research project. By introducing the field of Linguistic Pragmatics as well as describing essential components of face-to-face interaction, the study of spoken interaction (3.2) is reviewed first. In an attempt to better understand talk-in-interaction, Conversation Analysis (3.3) is used as the theoretical framework for investigating and describing the spoken interaction which is in focus in this study. Existing research on the forms, structure and challenges of medical discourse (3.4) is then discussed in order to orientate and identify VCT as a type of conversation. The chapter concludes with an exposition of the literature that describes the features, functions and forms of hearer signals (3.5), a linguistic phenomenon that has been recognised as characteristic of VCT and is found to be widely distributed in VCT conversation.

3.2 THE STUDY OF SPOKEN INTERACTION

In his exploration of causality and of the functions of texts, Austin (1962), working in language philosophy, introduced a new perspective within the study of meaning. Where linguistic semantics in the late 1950s was largely the study of the literal meaning of words and sentences with minimal attention to context, Austin's work paved the way for a linguistic subfield in which the contribution of context to meaning was seriously considered. Thus in Linguistic Pragmatics the interest shifted from language in the mind (competence) to language in use (performance). The functions of spoken text within its social context started to receive scholarly attention. This resulted in new theorisation about the ways in which people communicate. Special attention was given to contextual factors that influence meaning, to inferences conveyed in speech acts, in verbal and nonverbal behaviour, and to communicative cooperation between speaker and hearer. This section discusses foundational work in the study of spoken interaction from such a pragmatic perspective. After introducing

the field of Pragmatics and referring to some of the key theories within this field, the critical differences between spoken and written text will be presented. Components of face-to-face interaction will be discussed before research about the ways in which participants cooperate to manage and maintain successful interaction is reviewed.

3.2.1 Pragmatics

When Austin (1962) started investigating “how to do things with words”, he drew attention to the intention of speakers who produce texts. He developed a theory of speech acts according to which three things are done in the process of uttering language within context, namely producing a locutionary act, an illocutionary act, and a perlocutionary act. He (1962:94) calls the “act of ‘saying something’ in [a] full normal sense” of utterance and sentence production, the locutionary act. Cruse (2011:363-364) elaborates that this refers to (i) the literal production of sound, (ii) the construction of a syntactically appropriate string of words according to a certain grammar, and (iii) the transference of basic meaning despite the possibility of potential ambiguities or expressions of reference. Austin (1962:98) then refers to the way in which and reasons why the locution is used. Thus the act of doing something with words, such as baptising a ship or marrying two people, is called the illocutionary act. Following Austin, Levinson (1983:236, *italics in original*) calls the component of meaning that determines the function of an utterance the “conventional *force* associated with” the locutionary act. In explaining how the illocutionary act is internal to the locutionary act, Cruse (2011:364-374) provides a description of the implicit or explicit nature of these acts. The outcome that follows from a locutionary act in the form of “certain consequential effects upon the feelings, thoughts, or actions” of various communicative participants is denoted as the perlocution or perlocutionary act (Austin, 1962:101). In this way, language is used as an instrument in performing a specific act within a given context.

Taking context into account, Searle (1969), whose work developed the ideas first proposed by Austin, emphasised the importance of studying speech acts within conversation as a rule-bound form of communication. He (1969:17) acknowledged that the act of speaking not only has formal features that should be studied, but that its practical role within its context should be studied with equal rigor. This paradigm shift from interpreting language purely within formal semantics (i.e., utterances as locutionary acts), to understanding the implied or intended meaning and consequences of spoken text within context (i.e., utterances as illocutions and perlocutions) made way for the linguistic subfield of Pragmatics.

An overview of some pragmatic theories regarding the way in which people use language in communication follows. Many of these theories have developed in response to another in the sense that one criticises or aims to address the shortcomings of another which addresses the same communicative phenomenon. The following theories directly and indirectly inform the analyses of this study (chapters five and six), supporting the characterisation of pre-test HIV counselling within VCT as a type of conversation. Reference to some of these theories will be made as each attempts to describe some aspect of spoken language and how it is used in context in communication.

In theorising about the way people use language, Grice (1957) essentially suggests that communication behaviour is guided by a comprehensive set of rules (maxims) through which participants efficiently cooperate in language use during conversation (Levinson, 1983:101). Within this theory of implicature, Grice articulates general principles that he finds adhere to the primary principle of cooperation in conversation. According to the cooperative principle speakers typically structure their verbal contributions aligned to the context of the interaction in a way that will maximise the communicative success. These principles are perceived as logical guidelines rather than rules (Cruse, 2011:419-420). Below follows a summary of Cruse's (2011:417-9) description of Grice's maxims; the maxims are subject to the principle of cooperation.

First, the "maxim of quality" is concerned with truthfulness. According to this principle, interlocutors do not utter information lacking sufficient evidential support and they do not intentionally give false information. Second, speech acts typically carry as much information as is required in the context without being overly informative. This constitutes the "maxim of quantity". Grice's third principle, the "maxim of relation", explains how utterances are structured to contain information appropriate to the ongoing talk, i.e. speakers give information that has relevance to the topic. The fourth maxim, the "maxim of manner", is one that is adhered to in order to avoid obscurity and ambiguity by making the contribution textually concise, orderly and clear.

Sperber and Wilson (1995)¹² developed their pragmatic theory of Relevance on the basis of Grice's work. They found the postulation of four maxims redundant; instead, they posited that the aim of cooperation in conversation is achieved by adherence to a single encompassing principle, namely that of relevance. Their theory accounts for inferential interaction in terms

¹² This reference is the second edition of the original, 1986 source.

of an inherent cognitive intention to seek and preserve maximal understanding on the basis of what is manifest to all participants. Their central claim is that “the expectations of relevance raised by an utterance are precise ... and predictable enough, to guide the hearer towards the speaker’s meaning” (Sperber & Wilson, 1995:250). Throughout communication, a hearer is confronted with various stimuli (whether explicit or implicit) that can contribute to understanding. A hearer, according to Relevance Theory, intuitively selects the stimulus that connects to the information at hand which produces the most applicable conclusions within the context. Sperber and Wilson (1995:251) call this the “positive cognitive effect” holding that individuals select the most relevant input which contributes to the most meaningful inference and that “the greater the positive cognitive effects achieved by processing an input, the greater its relevance will be” (Sperber & Wilson, 1995:252). A speaker, according to the same theory, does not merely attempt to influence the thoughts of hearers, but also aims to bring about an understanding of her/his intention (Sperber & Wilson, 1995:255).

Besides more elaborate theories of meaning-in-context, a number of concepts central to Linguistic Pragmatics can be mentioned. In face-to-face interaction, reference is regularly made to external entities, “things” that exist outside of language. In pragmatics, the distinction between ‘reference’ and ‘sense’ is an important one for understanding the link between language and non-linguistic reality. Using language in reference is a way of connecting the language used in communication with the physical world, that which is the subject of communication. The term “sense” refers to abstract meanings of words or phrases; “reference” “is concerned with designating entities in the world by linguistic means” (Cruse, 2011:381).

When reference is made to entities that are specific to context and of which the meaning only becomes clear with contextual information, such referential meaning is called “deixis”. By encoding contextual entities, deictic references contribute to a participant’s understanding of what is being referred to (Levinson, 1983:54). Thus deixis is a crucial aspect of meaning, not only in Pragmatics generally but also within Relevance Theory as it provides participants with direct access to the most relevant contextual stimuli. It can be used to refer to (among other things) individuals, space, time, or discourse, and can also be evinced symbolically or gesturally (Cruse, 2011). If it is used to refer to an entity that is not present in the direct context, additional linguistic specification is required in order to overcome its abstraction (Arista & Moreno, 2004:69).

Another interesting phenomenon of Linguistic Pragmatics relevant to this study is identified as ‘presupposition’. Grundy (2000:119) describes this as a means through which participants in a conversation share existing knowledge which does not need to be verbalised explicitly. In this way when an utterance is produced, participants draw appropriate inferences from their common world-knowledge in order to determine the function and meaning of the utterance.

Reference to the Pragmatic theories as they have been discussed above, is mainly done with the aim of developing an orientation to the broader field of linguistic pragmatics in which discourse studies and CA are situated. In this way, although the theories are introduced very briefly, the researcher’s selection of CA as an important theoretical framework for this study, is explained. Notes on Speech Act Theory and Relevance Theory have merely been provided as a way of setting the scene, also in showing how various approaches developed and often anticipate and rely on one another. It is neither possible nor advisable to use such framing in the particular analyses of this dissertation.

3.2.2 Spoken versus written language

Linell (1982:5-10) provides a detailed list of differences between spoken language, or “speech communication”, and written language, “[c]ommunication by written texts”. Bavelas and Chovil (2000:165) summarise these differences within their argument that visible acts of meaning such as gestures and facial displays are an integral part of face-to-face communication which is not available in written communication. A summary of both Linell (1982:5-10) and Bavelas and Chovil’s (2000:165) contrasting of spoken and written text is presented below.

To begin with, spoken text is ephemeral and dynamic in the sense that participants react immediately in real time; the language is not captured, which makes it difficult to review. In contrast, written text is a static artefact that rarely requires immediate reaction from participants and can repeatedly be reviewed. Spoken text is essentially a continuous action in which words are combined in a steady stream of speech sounds to form a progressively structured dialogue. Written text, on the other hand involves the production of discrete symbols as words that form a spatial structure that can be visually identified.

Another point of contrast involves context, an element on which spoken text is highly dependent. Participants in face-to-face interaction share a location, making the recipient of text present in the “social interplay” of dialogue. Paralinguistic phenomena and deixis can

contribute to meaning, and referential terms need not be explicit. Then the location, context and all features of the spoken interaction contribute to what the dialogue communicates. Compared to spoken text, written text requires exceedingly more in terms of explicit words and generic textual structure in order to be decodable (Linell, 1982:8-9).

Lastly, the ways in which knowledge of the skills underpinning the production and interpretation of spoken and written text are acquired, differ. While speech is largely unconsciously acquired at an early age as part of primary socialisation and skills in dialogue are developed through interpersonal contact, knowledge of reading and writing develops later as a secondary part of socialisation and only through conscious processes of learning (Linell, 1982:7&9). Additionally, spoken text accommodates variation and is flexible regarding some rules, whereas written texts mostly need to adhere to consistent norms which restrict variation.

3.2.3 The social situation

With the development of Speech Act Theory, Austin (1962) and Searle (1969) shed light on the importance of studying the intentions underlying speech acts within a given context. In the field of Pragmatics, Goffman (1964:133) reports on “two currents of analysis” in the study of speech behaviour. The first emphasises the importance and role of social variables in everyday speech behaviour, the second focuses on the linguistic and extralinguistic features of speech. In addition to these analysable contributing elements, Goffman (1964) comes to introduce what he calls the “neglected situation”. At the time of his writing in the early 1960s, formal linguistics had given little analytical consideration to the social “situation” in which language was produced. He drew attention to the neglect of attention to circumstances in which all instances of social interaction take place, and in which language is embedded.

This “social situation” varies, exhibiting different properties and principles which co-determine the structure of the conversation. Those interested in how linguistic features correlate with content from a social perspective have to consider the entire social situation in order to attribute the intended meaning to the text. Those interested in the physical features of spoken language will also need to take the context, the entire physical environment, into account. It is “an environment of mutual monitoring possibilities, anywhere within which an individual will find him- or herself accessible to the naked senses of all others who are ‘present,’ and similarly find them accessible to him” (Goffman, 1964:135). Before, during

and after a conversation a social situation therefore exists every time two or more people are in each other's presence. Goffman (1964:135) introduced the terms “gathering”¹³ and “encounter”¹⁴ to refer to the situational context in which spoken language is produced.

Goffman's understanding of the social situation is especially relevant to the theoretical approach of this study and is foundational to the upcoming analysis in chapter five. The social situation, or context in which VCT takes place is very specific and to an extent forces its participants to take specific interactional roles. The counsellor, who is familiar with the context, protocol and processes, comfortably takes the dominant role in guiding the conversation according to certain topics that have to be covered during the session. For the patient, especially a first-time patient, the context and all it entails, is unfamiliar. As a stranger to this social situation, patients mostly take a passive role, thus allowing the counsellor to guide them. The consequences that this social situation has for the participants and their contribution towards the conversation (which is discussed in chapter five), emphasise the importance of taking the social situation into account.

3.2.4 Participants

Every interactive communicative process will have at least two participants. There can be no hearer without a speaker; conversely, a speaker without a hearer either has an imagined audience or the speech will not count as communication. Goffman (1963) investigated this phenomenon when he started focusing on what he refers to as “*face engagement* or an *encounter*”, the situation in which two¹⁵ (or more) people are present and might “engage one another in focused interaction” (Goffman, 1963:89, italics in original). Alternatively, an individual who is not part of the conversation at hand, can be called a “nonparticipant” (Goodwin, 1981:3). With regards to co-presence of participants, Goffman (1963:17) finds that any participant must be in close enough range of the other to be (i) able to produce sensory output that can be perceived and interpreted by the other participant(s), and (ii) perceivable in

¹³ All participants in a social situation, regardless of their behaviour, form a gathering in which the behaviour of the participants is prescribed by what their cultural norms determine. Goffman (1963:91, italics in original) identifies a “*fully focused gathering*” as an encounter where two participants exchange speech acts, “*partly-focused*” gatherings in which there will be individuals who, although they are part of the situation, might not be actively engaged in the given encounter, as well as “*multifocused*” gatherings, where – in the case of more than three participants – there might be more than one conversational encounter taking place in the situation.

¹⁴ Encounters refer to the concentration of participants' visual and cognitive attention on one another paired with the physical behaviour of coming together to face each other, and is governed by guidelines on how to conduct the encounter in terms of structure and physical behaviour from start to finish.

¹⁵ Cf. Goffman (1979a:9-10) for phenomena found in social situations with more than two participants that are less obvious with only e.g., dominating communication, subordinate communication, byplay, crossplay, and sideplay.

this “sensing of being perceived”. By using their senses to perceive and interpret each other’s intentions in the conversation despite influential variables,¹⁶ Goffman (1963:15-16) announces a vital aspect innate to face-to-face interaction: “each giver is himself a receiver, and each receiver is a giver.”

To introduce the terms, “speaker” and “hearer”, Bublitz (1988:144) identifies three ways of describing these two roles in interaction. Looking at communicative actions, he posits that on a basic level, speaker and hearer can be determined by means of who is speaking and who is listening. He further acknowledges how different participants’ interactive rights can be used to describe a speaker (having the right to speak) or a hearer (having the right to hear). Taking a structural perspective, he then points out how the different roles of turn-taking (cf. 3.3.4.1) can be used as a description of participant roles. Here, speaker and hearer can be determined around the process of speaker change, with the speaker being the participant dealing with the speaking unit prior to the speaker change, at which time the hearer does not have claim to the speaking unit.

3.2.4.1 *Speaker*

The participant who has the floor, or is busy with a turn, will be called the speaker (Goodwin, 1981:3). The role of the speaker is tied to the turn at hand, which means that even in silence, whoever holds the floor at that time, is still perceived as the speaker. In accordance with Sacks et al.’s (1974:704) rules of turn-allocation, Rodrigues (2005) lists the possible “in-turn” activities of the speaker as (i) taking the turn, with or without interruption of a previous speaker, or with or without having been chosen by a previous speaker, (ii) maintaining the turn, with or without the risk of losing it, and (iii) handing over the turn, whether obliged to or not.

Goffman (1979a:16-17, italics in original) lists three roles¹⁷ a speaker can take in the conversational process. The basic role of the “*animator*” is assigned to the person who is in the position of producing understandable utterances. The “*author*” is the person behind the words spoken by the animator, the one who chooses the perception or feeling of the message as well as the words in which this message is brought across. Lastly, the “*principal*” is the person “whose position is established by the words that are spoken” (Goffman, 1979a:17).

¹⁶ Variables such as obstacles or the temperature of the physical environment are listed as potential influences on the senses of participants (Goffman, 1963).

¹⁷ Clark (1996:20-21, italics in original) refers to these roles as the “*formaliser*”, “*vocaliser*” and “*principal*”.

Similar to the previous role, by being the principal, a person does not necessarily utter the words, but with it being uttered, takes a stand in solidarity with the message that is being transferred (cf. Goffman, 1979a for examples).

3.2.4.2 *Hearer*

The hearer, also referred to as listener, auditor and addressee, in contrast to the speaker, is the person who at a given time does not hold the floor and is not in fact, speaking (Goodwin, 1981:3). Rodrigues (2005) summarises the “out-of-turn” activities of the hearer as (i) returning the turn by agreeing or disagreeing with the speaker, as well as (ii) yielding the turn. Although it is assumed that the hearer is passive in this process, s/he is not necessarily silent. Hearer utterances supplying feedback to the speaker throughout the speaker’s turn are identified as hearer signals (Rosenfeld & Hancks, 1980:193).

When assuming the role, a hearer can essentially choose between three kinds of responses to a speaker’s actions. S/he can (i) inform the speaker that s/he understands and is following as a means of supporting the speaker, (ii) provide constant feedback of her/his continual state of understanding as s/he is listening, or (iii) be indifferent towards the speaker by providing minimal or no indication of participation, understanding or interest. The latter is, however, least likely when the speaker has a long turn, since most feedback signals are produced instinctively (Clark & Krych, 2004:77). In reaction to the three possible roles that the speaker can assume in turn-taking (as mentioned above), the hearer has to take the roles of “*identifier*”, “*attender*” and “*respondent*” to successfully participate in the joint activity of interaction (Clark, 1996:20-21, italics in original); after attending to the vocal utterance provided by the speaker, the hearer must interpret and identify the utterance with the aim of understanding it in order to respond appropriately.

It is important to distinguish between the terms “hearer” and “addressee” in this regard as a participant can still be the hearer of speech without being the one that is addressed or singled out by the speaker in this way (Clark & Carlson, 1982:332). In conversations with more than two participants, for example, it is not always the case that the speaker is addressing no-one in particular, i.e., the group as a whole. It is more probable that the speaker will direct his speech at a single participant in which case unaddressed participants, or “side participants” (Clark & Carlson, 1982:343), will be aware that they are not directly addressed. The identification of the addressed participant can additionally be revealed through visual cues (Goffman,

1979a:9), “physical arrangement, conversational history, manner of speaking, and linguistic content” (Clark & Carlson, 1982:346). Typically, the next speaking turn will be handed to the addressed hearer (Goffman 1979a:9; Sacks et al., 1974:704). This action of setting the addressee apart from her/his unaddressed counterparts, creates a type of pressure for the addressee, as s/he is expected to take the offered role of next speaker (Goffman, 1976:260).

3.2.4.3 *Overhearer*

Besides characterising the hearer, Goffman (1979a) also identifies listeners who play only a passive role in the given conversational situation. Such participants are characterised as outsiders to whom Goffman refers as those who “*overhear*”, whether it is intentional or not. He (1979a:8, italics in original) then distinguishes between outsiders who are intentionally listening to what is being said, or “*eavesdropping*”, and those unintentionally listening, or simply “*overhearing*”. In other words, it could be the case that “a ratified participant may not be listening, and someone listening may not be a ratified participant.” A distinction is also made between addressees and overhearers by examining the attitude of the speaker (Schober & Clark, 1989:212; Clark & Schaefer, 1987:209). These researchers find that it is the responsibility of the speaker to make sure that the information being transferred is understandable and understood by the addressee. In the case of the overhearer, conversely, Clark and Carlson (1982:344) suggest that the speaker, as s/he is aware of the overhearer(s), could employ tactics which could cause the overhearer(s) to form “correct hypotheses, incorrect hypotheses, or even no coherent hypotheses at all” (cf. Clark & Carlson, 1982:345-346; Schober & Clark, 1989:211).

The duty of assigning the roles described above lies with the speaker, according to Clark and Carlson (1982:343). With the different roles in mind, they suggest that the speaker will start a process called “audience design” during which s/he will separate hearers from overhearers before allocating the role of addressee(s) to whomever will be the focus of her/his attention during the speech act (Clark & Carlson, 1982:343). Clark and Carlson (1982:343) suggest that this can be achieved through the way in which the speaker aligns her/himself to his audience, or the specific way in which s/he formulates her/his utterances. Since the role of speaker and hearer changes throughout interaction however, this explanation may become vague. It could rather be argued that the participant who initiates the speech event and the turn-taking therein influences participants in terms of role assignment.

Contrastively, it can be argued that the person with authority in a communicative event has the power to assign roles. After being assigned the role of speaker, the next speaker can ultimately decide whether or not s/he will answer and comply with the assignment of roles. Regarding this process in pre-test VCT counselling sessions, the data in this study consistently show the counsellor as conversation initiator to clearly be in control. It then becomes interesting to see how the patient takes on a passive role of following the cues of the counsellor, or tries to challenge the directions given by the counsellor by taking or holding a turn that has not been assigned to her/him.

3.2.5 Dialogue

Although one might argue that maintaining a monologue should be easier than taking part in a dialogue, “humans are [rather] designed for dialogue” (Garrod & Pickering, 2004:8). All communication requires at least two participants. Although more than two are often found which affects the process of meaning-making, this section will simply describe interactions as if between two as the data in this study mostly provide conversations between two interlocutors (and where there are three, the third is usually a silent participant). Schober and Clark (1989:211, italics in original) provide two views regarding understanding between two participants within conversation. Firstly, the traditional, or “*autonomous view*” argues that a non-speaking interlocutor receives messages from the speaker, decodes and interprets the language, and makes meaning from the code by cross-referencing the information against what is commonly understood between the participants within that context. The second, “*collaborative view*”, goes beyond this one-sided outlook and hypothesises that participants collaborate in order to ensure mutual understanding throughout the conversational situation. For Clark (1996:3) conversation is a joint activity in which more than one person at the same time in the same physical space actively work together in order to achieve conversational success. He calls it the “joint action that emerges when speakers and listeners – or writers and readers – perform their individual actions in coordination, as ensembles” (Clark, 1996:3), whereas Garrod and Pickering (2004:8), suggest that participants make use of a “processing mechanism that [they] call interactive alignment.”

3.2.5.1 *Interactive alignment*

As both Grice's co-operative theory of communication (which explains how meaning is created in e.g. implicature) and Sperber and Wilson's Theory of Relevance indicate, participants actively cooperate in order to maintain successful interaction (Garrod & Pickering, 2004:8, Clark, 1996:3). (Cf. section 3.5.1 for a discussion of the hearer's role in this process.)

Whenever we use language we are faced with such a co-ordination problem. As speakers we have to select expressions to convey what is intended and as listeners we have to select interpretations for those expressions in the hope that they will capture the intended meaning (Garrod & Anderson, 1987:184).

Johnson-Laird (1980) introduced the idea that people's understanding of the world is based on their construction of a "mental model"¹⁸ thereof. He credits Craik (1943:61) for introducing the idea of organisms possessing and making use of an internal mental version, or "small scale model" of a phenomenon originally found in reality. Van Dijk and Kintsch (1983:11-12 *italics in original*) call this model the "*situation model*". They (1983:237-241) mention the schematic strategies through which individuals assign cognitive superstructures derived from contextual information to build a schema. In this way, cultural, social, pragmatic and interactional information can be associated with different phenomena, events or discourses. Johnson-Laird (1983:2-4) elaborates on this mental model explaining that it is dependent on a person's understanding of a specific phenomenon which will vary from person to person as each has her/his own knowledge or beliefs – whether rudimentary or intricate – of a given phenomenon. He (1983:10) additionally states that these models, "merely imitat[ing] ... reality", are more basic and can thus not be perceived as complete simulations of their original counterparts.

When individuals with distinct mental models come into contact through interaction, they need to bridge the differences of their (un)shared and (dis)similar social frames of reference and experiences. It is a rudimentary property of conversational exchange that "[o]ne of the vital tasks in the conversational contact is to overcome the combined effect of the conversation differentials" (Allen & Guy, 1974:30). The overcoming of different mental models in conversation is an aim which determines the structure of communication around an

¹⁸ Johnson-Laird (1983:11), distinguishes between "artificial" and "natural" models. The former, like mathematics, is a kind of knowledge that needs to be actively learned in comparison to the latter, which is knowledge that can be acquired naturally and intuitively, like that of language comprehension.

“overall conception” that should be mutually understood (Garrod & Anderson, 1987:182). In their paper on brain to brain “coupling”, Hasson, Ghazanfar, Galantucci, Garrod and Keysers (2012:114) suggest shifting the paradigm of how individuals construct their reality from an action that takes place on an internal or individualistic level, to one that has an external, interpersonally achieved one, i.e. they argue for “a shift from a single-brain to a multi-brain frame of reference.” It is the responsibility of the participants to align their situation models that consist of “multi-dimensional representations containing information about space, time, causality, intentionality and currently relevant individuals” (Garrod & Pickering, 2004:8). Many researchers have attempted to provide theories that will account for this process of getting minds to meet in communication. Below a few of the most influential of such theories on spoken interactive communication are briefly described.

(i) *Mutual Manifestness*

Sperber and Wilson (1995:39) introduced the concept of ‘mutual manifestness’ which is one that works with the understanding that if something is manifest to a person, it is “perceptible or inferable” by that person. When two participants with the same visual/perceptive abilities enter the same physical environment, Sperber and Wilson hold that what is manifest to both participants then intersect to become “mutually manifest”. Participants then share a range of observable facts within that shared space. These participants, who are taken to be sharing similar cognitive abilities, will therefore be capable of making similar assumptions (Sperber & Wilson, 1995:39-40) regarding the contextual phenomena around them that guide them in understanding reference and finding agreement on interpretation. Where some state that communicative intention should be overt and that physical factors are essential in meaning making, Sperber and Wilson (1995:60) find that for communication to succeed, mutual manifestness is the primary requirement.

Mutual manifestness as a central concept within the development of Pragmatics as a recent linguistic terrain has been preceded by various attempts to describe collaboration between interlocutors as a crucial part of successful communication. Some of the harbingers regarding the concept of mutual manifestness are provided below.

(ii) *Speaker and listener models*

Horton and Keysar (1996:92) identify the underestimated importance of the way in which speakers keep their knowledge and perspective of listeners in mind during utterance

production. Sacks et al. (1974) introduces the concept of ‘recipient design’ as an interactive norm which they describe as “one aspect of the produced orderliness of conversation” (Liddicoat, 2011:6). By introducing “speaker models” and “listener models”, Clark and Marshall (1981:55) suggest that participants access their models of each other in the preparation for production of utterances or the interpretation thereof and constantly update their knowledge in this model through interactive alignment. Speakers in conversation tend to plan their utterances based on the types of commonalities they share with the hearer (Schober & Clark, 1989:211).

In accordance, Clark and Marshall (1981:55-56) account for the undertakings and change in dynamics when a new participant with a new model of references and (potentially different) shared knowledge enters the conversational situation and needs to be accommodated. They (Clark & Marshall, 1981:56) argue that each participant is responsible for “upholding the social imperative of keeping their models of each particular listener straight” as it is the foundation on which mutual understanding can be maintained. They compare this suggested linguistic procedure of anticipating the mental state of the addressee to a kind of cognitive encyclopaedia in that various bits of information are “compartmentali[s]ed into useful units” that participants can choose to access at a specific moment.

To explain, they use the example of speaking to different people at a party. In the case where you first speak to an L1 English speaker and then to an L1 French speaker, they suggest that by making this shift, an interlocutor may feel that s/he is “changing gears”, linguistically speaking (Clark & Marshall, 1981:55). With this they mean to say that depending on the addressee or other participant(s) in the conversational situation, the speaker might choose to access different units of the encyclopaedia based on specific features of the recipient of her/his utterances. Garrod and Pickering (2004:10) then suggest that the common ground that speakers and hearers find on the basis of being in the same space enables them to be inherently aware of each other’s state of mind, facilitating the conversational process.

Regardless of the context, these models of states of mind of the other are built from the first time two people meet and start exchanging utterances. In a formal context, like that of the HIV pre-test consultation investigated in this study, the structure will be similar to that of people meeting for the first time. With counselling sessions, the event typically is made up of questioning and answering as well as information-giving and information-receiving. In this way, the counsellor builds an initial model, or updates an already existing mental model of

each patient. In addition, due to the specific context of these counselling sessions, one can assume that the HCP will enter the counselling session with an already prepared and accessed part of the linguistic encyclopaedia that coincides with her/his model of the listener in order to maximise flow of conversation as well as facilitate mutual understanding.

(iii) *Grounding*

The way in which Schober and Clark (1989:212-213, italics in original) account for the collaborative feature of communication is by positing what they call “*grounding*”. For them this is a process of which the aim is “to establish the mutual belief that the listeners have understood what the speaker meant to a criterion sufficient for current purposes.” In communicating, they find participants count on a belief that a specific reference or question (e.g.) produced by the speaker will only be completed (communicated and so understood) once the hearer has indicated understanding. The mutual belief of this understanding may be established between the interlocutors immediately, or over the period of a few conversational turns¹⁹ (Schober & Clark, 1989:213).

(iv) *Interactive alignment*

The process of interactive alignment is mostly not explicitly discussed within a conversation, but rather tacitly established by the way participants use one another’s word choice, different sounds, grammatical forms and meanings. Garrod and Pickering (2004:9) suggest that this aspect of communication is a non-linear, “low-level” alignment (by means of vocabulary, sentence structure, etc.). When participant A for instance has a certain mental representation of a thing/action/circumstance, the process of talking is said to facilitate participant B’s alignment of her/his representation to that of participant A’s. This uniform representation which will lead to alignment of situation models on a more “critical level” is the basis on which communicative success is measured and is formed during the on-going process of producing and interpreting utterances²⁰ (Garrod & Pickering, 2004:9). Within this exchange the words, sounds, grammatical forms and meanings that are uttered by the speaker will influence the hearer’s representation and therefore stimulate a specific response from the hearer, which “leads to imitation” as evidence of interactive alignment (Garrod & Pickering, 2004:9). This social “innate tendency to imitate” (Dijksterhuis & Bargh, 2001:1) causes

¹⁹ Cf. Schober and Clark’s (1989:213) four “time points” within a conversation as part of the grounding process.

²⁰ Cf. Garrod and Pickering (2004:10) for a diagrammatic depiction of the way in which two interlocutors take turns at producing and interpreting utterances.

spoken utterances to trigger similar representations in the mind of the hearer which influences the hearer's reaction which in turn makes way for the "alignment of those representations between interlocutors" (Garrod & Pickering, 2004:9).

3.2.5.2 Problems in dialogue

In anticipation of understanding how participants in a conversation reach and maintain this common ground or shared foundation, Garrod and Pickering (2004:8) pose two dialogical problems. First, utterances in conversation are not always complete and second, it is difficult to foretell how a conversation will develop.

As opposed to formal writing, spoken utterances are not always grammatically perfect and can be cryptic and fragmented. Consequently, it is important for the hearer to be able to interpret the way in which the speaker brings explicit and implicit meaning across. The speaker, however, should – much the same as the hearer – also interpret the reactions presented by the hearer at any given time in the conversation. This is specifically applicable to the current study since it is important for the counsellor to be able to interpret and understand any nonverbal signals provided by often limitedly responsive patients as such signals indicate information processing and understanding. The counsellor's brief is to assure good understanding of prescribed information, therefore her/his recognition of nonverbal indicators of aligned representations is very important. Garrod and Pickering (2004:9) refer to the value of interactive alignment relying on Morgan's (1973) work regarding sentence fragments and the notion of a 'sentence'. They suggest that the alignment of the representations of the participants allows for the omission of redundant information that is common contextual knowledge or mutually manifest; in utterance production they believe it is this alignment that removes possible confusion because implied information can be inferred.

An apparent feature of spoken language is that the hearer cannot foresee when the opportunity to take the floor will arise, or what kind of reaction is to be expected. Such unpredictability complicates planning of conversation. Additionally, the speaker needs to be aware of what kind of information to share and – depending on the context – should be attentive to the degree of appropriateness thereof (Garrod & Pickering, 2004:8). Here, Garrod and Pickering (2004:9) refer to the feature of interactive alignment in which high-level planning rests with both participants, where initiatives in terms of turns alternate between the two. The speaker (by asking a question, for example), specifies the type of reaction (i.e., an answer in this case)

that is expected from the hearer (a “preferred response”). It is not only on a semantic level that this reaction is determined; the way in which the speaker formulates an utterance can also affect the structure of the hearer’s reaction through lower-levels of interactive alignment. Garrod and Pickering (2004:9) suggest that this kind of lower-level alignment is manifested through lexical repetition as well as the repetition of syntactic structure throughout speech sequences between interlocutors. Finally, the shared common ground explains the interdependence of collaborative processes of producing and interpreting utterances. This shows how task-switching between speaker and hearer assists in addressing issues of the unpredictability of conversation (Garrod & Pickering, 2004:10).

3.3 CONVERSATION ANALYSIS

Despite its historically universal abundance, the phenomenon of conversation as spontaneous and unscripted oral communication has only recently (since the early 1960s) become the topic of scientific analysis (Ten Have, 1999:3). On the most basic level, Conversation Analysis (CA) addresses what has been discussed in the previous section in that it studies instances of communicative practices in social interaction, or talk-in-interaction. Although the earliest work in CA referred to talk in informal contexts such as telephone conversations (Sacks, 1992), this form of analysis is currently used in many more contexts, also formal conversation and in scientific fields other than Linguistics. This section will introduce the foundations of CA as an analytical framework and will discuss some of the literature on its application within formal institutional settings.

3.3.1 The development of CA

CA is known to have emerged from Garfinkel’s (1967) approach to understanding social inter/action, called ethnomethodology.²¹ In short, ethnomethodology investigates the ways in which individuals make sense of the world around them (Wynn, 1995:28). It claims that all human action and interaction exist around participants’ shared knowledge and assumptions as to how they relate to their social reality. It is a field of study that takes an interest in the methods humans apply in developing what has become common sense in a given community. It aims to analyse the way in which individuals within one community, or “cultural colleagues” achieve and maintain “organi[s]ed activities in actual occasions with situated particulars of talk and conduct” (Garfinkel, 1967:11).

²¹ Cf. Garfinkel, 1967; Heritage, 1984; Psathas, 1979; Livingston, 1987.

Goffman (1964) first drew attention to the importance of studying ordinary instances of speaking within its social setting. After investigating, for example, the order of turns in conversation, he (1955; 1963) was able to claim that verbal interaction is not randomly structured, but is in fact socially organised. Sacks (1992), in his lectures on conversation from the 1960s expanded on this approach by introducing the study of social action illustrating the construction of social order through instances of everyday talk. Sacks et al. (1974) went on to establish the field of CA when they set out to characterise the organisation of talk.

3.3.2 The aim of Conversation Analysis

By recognising the need to investigate social actions in terms of their practical accomplishments in everyday social interaction, Psathas (1995:3) confirms the “ethnomethodological character” of CA. Similar to ethnomethodology, CA focuses on the understanding of the “*competences* which underlie ordinary social activities” (Heritage, 1984:241, italics in original). Both methods of research strive to analyse the techniques participants use in their collaborative effort to maintain successful communication in social interaction (Maynard & Clayman, 2003:174). Wynn (1995:28) distinguishes ethnomethodology from CA on the basis of the latter focusing on the functions of language rather than its form. Maynard and Clayman (2003:176) also report substantive and methodological differences in that CA’s focus is firstly more specific – on talk-in-interaction together with its components – and secondly more data-driven, using recordings of naturally occurring communication for analysis.

CA thus aims to make sense of the orderliness and organisation of human inter/actions. It assumes that this order is produced by participants on site, to serve as the general convention to which the participants orient themselves, and to be recurrent in nature as its structure can be repeated from context to context (Psathas, 1995:2-3). This conversational order should never be “dismissed as disorderly, accidental or irrelevant” (Heritage & Maynard, 2006:9). Psathas adds that the aim of the analyst is to investigate and describe “the *structures*, the *machinery*, the *organi[s]ed practices*, the *formal procedures*, the ways in which order is produced” by analysing the frequency of specific phenomena in order to provide a formal description of the structures of social inter/action. By focusing on the function rather than the form of language, CA emphasises the importance of meaning and context within interaction. Conversation analysts then study the meaning and context in terms of the observable

interactional sequences that make out the organisation of talk-in-interaction (Heritage, 2004:223).

The relevance of CA as a theoretical framework used for this study becomes clear in chapter five where communicative actions in pre-test HIV counselling sessions are studied in sequence and in relation to each other. Within any discourse, and specifically prominent in this conversation type, observing speech activities as emerging from action projection between participants is crucial. In this way, chapter five looks at the effect of speech activities of one participant (mostly the counsellor) on the other (the patient). The ways in which messages are conveyed, as is illustrated in the selected wording or phrasing, have an effect on the following utterance by the next participant. CA, with its focus on sequential organisation, provides the best platform for disclosing the features which mark counsellors' communicative practices and how they contribute to the failure of allowing and encouraging more patient participation.

3.3.3 Meaning and context

Heritage (1984:242, italics in original) emphasises the importance of contextual orientation of talk-in-interaction by stating that each contribution within interaction is both “*context shaped* and *context renewing*”. Actions that are context-shaped can only fully be understood within the context that they were performed, especially referring to the (immediately) preceding actions within the turn-taking process, whereas context-shaped utterances are in fact also context-renewing in that each communicative action (regardless of the preceding development thereof) then, in turn, establishes the contextual requirements that the following speaker's utterance must meet. In this way, each action will “function to renew (i.e. maintain, alter or adjust) any more generally prevailing sense of context which is the object of the participants' orientations and actions” (Heritage, 1984:242).

For this process of maintaining understanding within a context that is changing throughout, Heritage and Atkinson (1984:11, cited in Peräkylä, 1995:23) state that throughout conversation, participants continuously maintain “intersubjective understandings”. Peräkylä (1995:24-28) then discusses the “four layers of intersubjective understanding”. By responding with an appropriate utterance, the (current) speaker shows suitable (i) understanding of the previous utterance. Intersubjectivity is apparent when (ii) a topic change is introduced that reflects the understanding of the current context and is judged as a fitting alteration within

that context. Throughout ongoing conversation, (iii) utterance design needs to adjust appropriately to show understanding of changing contexts within talk. Finally, Peräkylä (1995:26) refers to Goffman's (1967:113-114, cited in Peräkylä, 1995:26) requirement of participants to collaborate in maintaining focused attention throughout utterances and turns which can easily change as conversation progresses. Despite participants' awareness of these implicit guidelines, however, a hearer can choose to either "conform to" or "non-conform to" the behavioural expectation created by the nature and form of the speaker's utterance (Wynn, 1995:28-29).

3.3.4 Rules of conversational sequence

During his first lecture in 1964, Sacks (1992, vol. I:4) introduced what he calls the "rules of conversational sequence." Based on his data (in the form of telephone conversations) he established that conversation is made up by "units" that come in pairs. He gives the example of greetings in a telephone conversation where person A can say "This is Mr Smith may I help you" to which person B can reply "Yes, this is Mr Brown." He also identifies the "procedural rule" stating that within these greeting units, the reply of the second person will tend to fit the utterance of the first. In this way, person A can choose the form of address that both participants will use in that specific unit.

Allen and Guy (1974:177) refer to these units as "cycles." They define each cycle as all the verbal items that take place between the start of the production of the first speaker's utterance up to the moment the second speaker finishes the responding utterance. They (1974:177) furthermore categorise their cycles into three distinct types, namely the "responsive"- "narrative"- and "null cycle". The responsive cycle is a unit in which the verbal productions exchanged contain informative utterances like assertions or questions. These cycles provide for a better balance between participants who are required to interpret all the information throughout the unpredictable process of navigating between speech turns and maintaining structure. The narrative cycle is formed when an informative utterance is produced by one participant while the other contributes with a type of verbal act that supports the flow of the conversation (i.e. supports, interjections, laughs or fragmentation). These cycles are applicable to situations such as this study in which complex information needs to be brought across from one participant (who possesses this information) to another (who lacks it) (Allan & Guy, 1974:178). Null cycles then refer to cycles in which assertions or questions lack as

both participants provide the cycle with what Allan and Guy (1974:177) refer to as “non-assertive material”.

The sequence²² in which these units or cycles form successful interaction on a turn-by-turn basis, is believed to always be orderly. Sacks et al. (1974) identify and elaborate on 14 observations about the orderly nature of communication throughout their studies and the development of CA. During the course of his analysis of the structures and underlying procedures evinced by participants in ordinary interaction, Sacks (1992) reported on the structure of conversational phenomena including turn-taking, adjacency pairs, interruptions, repairs, invitations, mis-hearings, as well as opening and closing of the conversation. Although literature on many more of what he (1984) classifies as the “machinery” behind the interactional process exists, below follows an introduction of turn-taking, adjacency pairs and openings and closings, a study of which Heritage and Maynard (2006:10) claim will provide insight to participants’ collaborated joint understanding, regardless of their socio-cultural background.

3.3.4.1 *Turn-taking*

The basic rule in spoken interaction is the fact that any on-going state of talk consists of turns at talk (Goffman, 1964:135). Identified by Yngve (1970:568) as probably the most noticeable, and Sacks and Schegloff (1973:289) as the most elementary feature of conversation, turn-taking can be characterised as the foundation on which the social activity of speaking is sequentially organised (Goffman, 1964:135). Goffman (1964:136) put forward the observation that speech behaviour is more than the directly involved elements like which language is spoken to which person. He illustrated how conversation is “a little system of mutually ratified and ritually governed face-to-face action, a social encounter” guiding each speaker in the maintenance of the interactional flow of talk (Goffman, 1955:226). Sacks (1992, vol. I:95) offers a description of the basic rule of sequential talk by breaking up the conversational action into units, namely the “ababab” (or “A-B Reduplicated”) formula where “a” and “b” are the conversational participants. This is also what Schegloff (1968:1076, italics in original) calls the “*one party at a time*” rule for conversation.

²² Sequences do not necessarily consist of merely two turns in conversation. Cf. Psathas (1995:21-26) or Sidnell (2010:Chapter 6) for a description of expanded sequences consisting of a “pre-expansion”, “insert expansion” and “post-expansion”.

Whenever more than one person is talking at the same time, more than one conversation might be occurring simultaneously (Goffman, 1976). Despite this basic governing rule, however, overlapping speech does exist, and is seen as orderly (Jefferson, 1973, 1975 as cited in Goodwin, 1986) and is often found in the form of hearer signals or back channel replies (Goodwin, 1986; Clark & Schaefer, 1989; Beach, 1993; Hirschman, 1994; Ward & Tsukahara, 2000; Kinnell, 2002; Clark & Tree, 2002; Lambertz, 2011). Evidence in which participants collaborate to repair overlapped speech is also reported (Sacks et al., 1974; Schegloff, Jefferson & Sacks, 1977).

It is the responsibility of the participants of the encounters to cooperatively construct the conversation. This can be done by requesting and giving up the floor by means of signalling (Goffman, 1964). Here, Sacks et al. (1974:703) introduce the “turn allocation component” in which a next turn can be allocated by the present speaker, or other participants can decide to take the floor, a phenomenon they call “self-selection”. They (1974) provide further insight on (among others) the rules underlying the management of turn-taking which include speaker change, turn order, size, distribution and allocation, as well as setting out the basic rules that govern the construction of turns based on their proposed model of speech exchange. Their (1974:704) basic rules for effective coordination of turn-taking are given in 1a-c:

- (1) Turns are to be exchanged at “transition-relevance place[s]” within a “turn constructional unit” and can occur in the following ways:
 - (a) If the current speaker selects the next speaker, it is the selected participant’s right and obligation to take the next turn.
 - (b) If the current speaker does not select the next speaker, any other participant may self-select to take the next turn.
 - (c) If the current speaker does not select the next speaker, s/he may continue and take the next turn provided that rule 1b does not occur.

The turn-taking process is further characterised in that it differs from context to context. Conversation has a linear nature in that it consists of a “one turn at a time” structure (Sacks, Schegloff & Jefferson, 1978:46-47). Different types of discourse with varying structures of pre-allocated turns are identified. Conversation allows for many variations, such as e.g. ceremonies and debates that are “the most extreme transformation[s] of conversation” in that their pre-allocated structures externally determine very set parameters (Sacks et al., 1978:46-

47). The recognition of differences in speech-exchange systems led to comparative studies between informal and formal talk-in-interaction (cf. section 3.3.5).

3.3.4.2 *Adjacency pairs*

Considering that utterances are both context shaped and context renewing, a pattern of “sequential implicativeness” (Schegloff & Sacks, 1973) can be formed as pairs of utterances go together. In describing these paired utterances, Liddicoat (2001:139) provides a list of core features of adjacency pairs – on which variations are possible and often occur – namely, (i) two turns uttered by (ii) different speakers (iii) of which the pair of utterances occur next to each other, i.e. one follows the other in direct adjacency. Moreover, these pairs are (iv) structured as well as (v) separated into pair types. Goffman (1976:257) calls this particular organisational structure “a couplet, a minimal dialogical unit, a round two utterances long.” Liddicoat (2001:139-140) elaborates that the “first pair part”, i.e. the initial utterance of the pair, involves the projection or setting of the criteria for the “second pair part” which completes the adjacency pair. The second pair part typically provides an appropriate response that is “conditionally relevant” (Clark & Schaefer, 1989:271). Examples of adjacency pairs include greetings, farewells, questions and answers, as well as responses to invitations²³. The relevance of including a brief exposition of adjacency pairs in this study becomes clear in chapter five where the types of adjacency pairs typically found in pre-test HIV counselling sessions are analysed.

Second pair parts can be “preferred” or “dispreferred” responses. E.g. if A asks B to do her a favour, the preferred response will be an indication of willingness from B. When second pair parts do not occur as expected, participants are found to initiate a repair on this dispreferred, often unconventional, yet common event in ways that support CA’s claim of the orderly fashion in which social interaction is produced (Maynard & Clayman, 2003:180). When the participant responsible for the second pair part does not provide a preferred response s/he will often show awareness of not responding appropriately and therefore (e.g.) provide an explanation for the absence of compliance. Then, in an associated sequence the first speaker could respond to the dispreferred second part by elaborating on the first pair part by providing additional information, thus expanding on the first part sometimes as a face-saving action, or perhaps to show understanding of the response. In other cases, before giving the second part (preferred or dispreferred) the second speaker can ask for more information which the first

²³ Cf. Mills (2014) for more literature on complementary structures.

speaker will then provide (Clark & Wilkes-Gibbs, 1986:19). For example, if A in the first part asks B to help her with something, before giving the second part, i.e. answering, B may start a new exchange and first ask how long it will take. A responds by saying how long, and on the basis of what A says, B will then design the answer to A's first question. Such elaborations that occur between the first and second parts of a sequence are called "insertion sequences" (Clayman & Maynard, 2003:180).

Bales (1950:54-55) names three kinds of actions that can be taken when participants experience a failure in the maintenance of their joint understanding, i.e. when an insertion sequence is required before the completion of the first sequence. The respondent in an adjacency pair can start an insertion sequence. The "[i]nitial act" is the failure or need for more information before compliance is signalled. This is followed by the problem-solving "[m]edial act" in which answers can be provided or repetition and elaboration given. Only then the "[t]erminal act" follows in which the initiator of the insertion signals that the medial act has been successful and collaborative alignment has been restored. Often the completion of the first sequence, e.g. the answer to the first question also counts as the terminal act of the insertion sequence.

3.3.4.3 *Opening sequences*

In his study of telephone conversations, Schegloff (1968) suggests, through his "distribution rule", that typically the person who answers the phone speaks first. After finding a deviant case, he sought to deepen his understanding of the conversational conventions by providing a more general formulation of the properties of opening sequences. He then theorises that the ringing of the telephone itself serves as the first pair part of a summons-answer (SA) sequence. He (1968:1080) elaborates that this sequence is not specific to telephone conversations, and that methods of summons, or "attention-getting device[s]" can be found in face-to-face interaction in the form of (i) "terms of address", (ii) "courtesy phrases", and (iii) "[p]hysical devices". He suggests completed SA sequences that function in opening a conversation to be nonterminal in that they are "preambles, preliminaries, or prefaces to some further conversational or bodily activity" (Schegloff, 1968:1081) and conditionally relevant. SA sequences have conditional relevance in that the production of the first part creates an expectation of the production of an appropriately suited second pair part. The presence of a second part is therefore perceived as a consequence to the first, whereas its absence will also

be accordingly noteworthy in that the lack of response also carries meaning in the interaction (Schegloff, 1968:1083).

Opening sequences in pre-test HIV counselling sessions are discussed in chapter five (5.3). In this section, the generic features of opening sequences mostly reflect the dominance of the counsellor as the participant guiding the conversation. In this way, the initial interactional collaboration sets the trend for patients to take a passive role throughout the consultation. Counsellors have been found not to challenge the patients or encourage them to lead the conversation and raise their own thoughts or concerns regarding the process. CA allows for an analysis of the specific types of sequences found in the opening of these conversations, such as the aforementioned speech act sequences, question-answer adjacency pairs, and information-giving speech activities. CA is helpful in that it also takes cases that don't fit the regular pattern into account. Deviations from the rule are useful in strengthening the theories that are based on observed sequences.

3.3.4.4 Closing sequences

Conversations as units do not merely end, but are “brought to a close” (Schegloff & Sacks, 1973:69). As with all sequences within talk-in-interaction, bringing a conversation to a close is a collaborative action managed and negotiated by the participants in that the process terminating a conversation “involves work ... [and] requires accomplishing” (Schegloff & Sacks, 1973:96). In their consideration of terminating a conversation, Schegloff and Sacks (1973) mention “possible pre-closing” as a way of initiating a closing sequence, which usually starts with discourse markers like “well”, “okay” or “so”. The majority of closing sessions analysed in this study (cf. section 5.4) are also initiated with pre-closing phenomena of the same kind as those introduced by Schegloff and Sacks (1973). They further mention that this attempt at initiating a closing sequence can be followed by two possible actions by a next speaker.

As a first action, the addressee can acknowledge the speaker's attempt to foreshadow an imminent termination. Schegloff and Sacks (1973:80) provide an illustrative adjacency pair as an example where the speaker utters “okay” to which the hearer (and next speaker) reciprocates and acknowledges by also uttering “okay”. As a second action in a possible pre-closing, the opposite of the intended action can happen as its production might prompt the addressee to continue, e.g. by initiating a new sequence, even introducing a new topic. “The

opening that a possible pre-closing makes for an unmentioned mentionable may thus result in much more ensuing talk” as the pre-closing can be interpreted as an occasion in which a sequence covering a new topic might fit appropriately (Schegloff & Sacks, 1973:80). In this way, they note that a pre-closing’s “central possibility” is to initiate a sequence in which termination will be accomplished, while the opening of a new topic is the alternative possibility (Schegloff & Sacks, 1973:87). White, Levinson and Roter (1994, cited in West, 2006:381) report that during general practitioner consultations which they studied, closing sequence initiation was mostly done by doctors, to which the majority of patients (82%) responded in displaying agreement and compliance whereas 21% of the patients took the alternative route by bringing up a topic that had not been mentioned earlier in the consultation.

Although the duration of a conversation is rarely exactly predetermined (Sacks et al., 1974:710), Clayman (1989, cited in West, 2006:379) mentions the way in which the duration of social occasions can reveal aspects of its nature. On an institutional level, for example, primary health care consultations are typically scheduled in terms of starting time without specific reference to the time or manner in which the session will be concluded (West, 2006:379). However, in some cases people are given advance notice that e.g. a consultation is for 15 to 30 minutes, or that an interview will last for 40 minutes, or that a person has to state a case in no more than 5 minutes. In the counselling sessions at the day clinics in this study, patients got to see the counsellor on a first come, first served basis. Therefore, for the exact time of commencement they had to wait their turn. Then the counsellor managed the duration according to a procedure which standardly had a duration of 7 minutes and 33 seconds²⁴ from start to finish.

3.3.5 Institutional Conversation Analysis

Although Heritage (2005:103) claims that CA’s application has been institutional from the start in the form of telephone calls to a suicide prevention centre (Sacks, 1992), its concern is said to have been in analysing the inherent structure of talk-in-interaction, regardless of the setting (Ten Have, 2001:3). Despite their initial focus on ordinary instances of relatively spontaneous social talk, Sacks et al. (1978) also mention the importance of the context on shaping its structure, e.g. in the turn-taking system, where a clear difference in terms of turn-

²⁴ This number is the calculated average time of the 14 sessions included in the analysis of this study. While the shortest session recorded in the data is 4:06 minutes, the longest session is 12:57 minutes.

taking is found between informal interaction and discourse types with pre-allocated turns, such as debating. CA only later started to be used to analyse face-to-face interactions in more formal, or institutional settings (Heritage & Maynard, 2006:9). The data collected and analysed in this study are from such a regulated institutional context.

3.3.5.1 Definition

In light of this focus, shift taken by many researchers in CA studies, Heritage (1997:162, *italics in original*) suggests that there are at least two types of approaches in CA: “[t]he first examines the social institution *of* interaction as an entity in its own right; the second studies the management of social institutions *in* interaction.” The contrast between the two lies in whether ordinary conversation or institutional interaction is studied (Ten Have, 1999:162) as Institutional CA aims to investigate how social institutions operate interactively (Heritage, 2005:104). Ten Have (1999:162-164) then reports that this “applied” CA (or study of institutional interaction) is different to “pure” CA (or “basic CA” (Heritage, 2005)) (or study of “conversation”) in that it is more “restricted” (Ten Have, 1999:164) in the sense that some informal conversational actions and related conventions are not included in the repertoire used in institutional contexts.

Drew and Heritage (1992:21-25) suggest that the features of institutional interactions are formed around the specific structures and procedures inherent to the nature of the institutional context at hand. They therefore characterise the interactions within this goal-orientated setting as being focused on performing the appropriate tasks and achieving specific aims according to the nature of the institution. Similarly, they are restricted by institutional circumstances in the same way Ten Have (1999) suggests. Heritage (2004:224) adds a reminder of the fact that participants of interaction in institutional settings usually have “institution-relevant identities” such as a counsellor and a patient and that research on turn-taking systems usually reveals a pre-allocated structure in the form of particular kinds of sequences such as question-answer sequences and quite rigid conversations regarding the organisation of turns between the institutional and lay person (Drew & Heritage, 1992:39).

3.3.5.2 Advantages of Institutional CA

In their review of studies of doctor-patient interactions (by Heritage & Stivers, 1999 & Peräkylä, 1997) Drew et al. (2001) report on the value of analysing institutional talk through

CA. They list the novel contribution that this type of analysis offers as it enables researchers to

- (i) recognise specific behavioural patterns, particularly how HCPs manage the interaction (which could be addressed in training),
- (ii) classify techniques employed to enhance patient-centred interaction, and
- (iii) analyse the relation between specific styles of interaction with specific observed outcomes (2001:59).

In terms of doctor-patient communication as institutional discourse, Drew et al. (2001) find applied CA to be valuable in that it provides a method for recognising and investigating the choices that HCPs make regarding structuring their turns. This is especially relevant to this study as the overall aim here is to identify the structure of pre-test HIV sessions as an institutional conversation type in order to recognise the ways in which HCPs manage the interaction with the ultimate aim of judging the degree of communicative success these conversations have. Further, techniques can be identified, analysed and, if needs be, addressed in later training sessions aimed at improving the conversation. On such possibility would be to develop ways of making the consultations more patient-centred.

In the summary of their report, Drew et al. (2001:67) list advantages of applying CA to HCP-patient interaction data. CA's concern with the organisation of talk-in-interaction by analysing observable interactional sequences consisting of specifically designed turns, makes its application to institutional talk such as HCP-patient discourses particularly suitably. The approach enables a researcher to monitor the effect of prior turns at talk on HCPs' selection of one behavioural choice above another, and in turn to monitor the sequential courses of action as a result of the specific chosen behaviour.

3.4 THE STUDY OF MEDICAL DISCOURSE: HEALTH CARE PROFESSIONAL-PATIENT COMMUNICATION AND VCT

Mishler (1984:7-8) acknowledges the importance of distinguishing medical interviews as a discourse in its own right which should be recognised and handled as an important conversation type. He argues that by investigating the workings of this discourse, one can gain a better understanding of the collaborative work in doctor and patient interaction, as consultations are a crucial part of clinical practice. He (1984:7) therefore proposes that

analysts aim to create an “empirically-grounded and theoretically meaningful understanding of clinical practice.” Although many studies have been done on this practice (cf. Argyle, 1983; Pendleton, 1983; Tate, 1983; Wynn, 1995), most topicalise doctor-patient communication which includes the investigation of power relations and the authoritative role of the doctor. A considerable number of these studies investigate the influence of the doctor’s imposing position on diagnostic consultations: the presentation of medical issues, history taking, diagnosis, treatment, etc.

The focus of this study, however, is on a different type of conversation in the medical discourse genre: pre-test VCT counselling sessions between a modestly schooled, but specifically trained counsellor and patient in a state care facility. The literature discussed in this section focuses on research applicable for understanding this specific discourse and includes the structure of medical consultations, an overview of the institutional communication formats found in this context, as well as the difference between sessions that are doctor or patient-centred. Finally, an overview of socio-cultural influences that affect the discourse will be touched upon. Throughout the discussion of these topics reference will intermittently be made to VCT as a discourse.

3.4.1 Structure

Initially, the counselling in VCT was carried out by professionals in psychology and psychiatry, who increasingly were assisted by social and other health care workers (Sherr, 1999:53). As the epidemic grew, however, so did the requirement of larger numbers of counsellors than were professionally schooled. This led to the training of lay counsellors (cf. section 2.4.2). Despite these efforts, there are still times where counsellors are overwhelmed by the number of patients they have to see. At clinic A (in this study) where only one counsellor is employed, there are times when pre-test counselling sessions are done in group format in the waiting area outside the consultation room in order to save time so that each patient can be tested individually thereafter. This in itself raises many concerns regarding language issues and the difficulties counsellors are likely to have to monitor patients for understanding.

When one-on-one HCP-patient communication is established, according to Heath (1986:25), the beginning of the consultation consists of activities such as the exchange of greetings, confirmation of identities, establishment of spatial and physical orientation by the patient, as

well as preoccupation with documents or other medical equipment by the doctor. In listing these, possible concerns include that both participants are only partially aware of the other's actions due to the lack of an established common focus between them. Attention that is prone to shift in this situation causes disjointed mutual involvement. Heath (1986:25) reports, however, that as soon as the participants move from these opening activities into the business of the consultation the state of affairs changes and they start collaborating to align their attention to establish what he calls, "a mutual focus of involvement." This inherent process in medical consultation, he argues, is mostly initiated by a display of reciprocity (cf. section 3.5.4.5).

Once this mutual focus of involvement is established, Mishler (1984:67-68) identifies three basic sequences within a unit of doctor-patient communication which is generally repeated throughout, forming the structure of the consultation. The common starting point of a unit normally takes the form of (i) a question from the HCP, followed by (ii) the patient's response which is then (iii) assessed by the HCP and can be followed by a next question to initiate the next unit. The same structure is found in counselling sessions throughout the question-answer phase (cf. section 3.4.1.1 below). In accordance with Drew and Heritage's (1992) comment on the features of institutional talk, Wynn (1995:14) states that the type of talk in this context is "to a certain extent, preplanned and that it proceeds according to certain, more or less well-defined rules."

In his study of AIDS counselling, Peräkylä (1995:45) identifies two types of speech activities generally carried out by counsellors: the asking of questions to patients, or making statements in the form of giving advice, information and commentary. He argues that participants assume their institutional roles, thus orientating themselves to the relevant tasks as well as its accompanying actions. These two types of speech activities also prominently feature in the study at hand and will receive more attention below.

3.4.1.1 Information-gathering sequences

Institutional talk is known for exhibiting specific conversational practices. Heritage (1995:409) identifies the features of question design in this context, for example, to "occur in greater concentration, or [to be] overwhelmingly produced by one of the participants." In his description of sequences as "*patterns* of subsequent actions," Ten Have (1999:114, italics in original) reports on the repetition of similar sequences that form observable cycles in

conversation. He refers to Sacks' (1972:343, cited in Ten Have, 1999:114) "chaining rule" stating that a questioner has a right to retake the floor after an answer is provided in order to ask another question. These types of question-answer chains, as will be illustrated in section 5.5 are also found in the general structure of pre-test VCT discourse.

In summarising the findings of a number of studies done on institutional talk-in-interaction, Drew and Heritage (1992:39) again state that not only is the turn exchange system pre-allocated, but also the style of the turns. The conversations consist mostly of questions from the institutional person and answers from the lay person. Ten Have (1999:166) considers possible advantages and disadvantages of such a system. The institutional person, who is given the role of questioner, is permitted to build as large a turn unit as needed on her/his own judgement, until a clear question is formed. What is required from the lay-person on the other hand, is a "minimally adequate 'answering' component" after which s/he can be interrupted by the HCP without elaboration or explanation in order to start a new basic unit within the interaction. This type of system resonates with HCP-patient interaction that is doctor-centred (see this discussion in more detail in 3.4.1.3).

In their study involving question-answer sequences between doctors and patients, Anthonissen and Meyer (2008:28) emphasise the elaborate use of questions²⁵ in doctor-patient HIV consultations. They report on the questions being direct and indirect, often taking the form of a statement with a tag-question. Patients are expected to comply with a specific set of eligibility criteria before being able to start with ART. Among other things, this means that patients need to show sufficient understanding of the virus, since this understanding reflects their potential for adherence to the strict medical regimen. The same requirements apply before an HIV test can be administered. HCPs therefore need to gauge patients' comprehension on different subjects during these consultations, which is often done by asking questions to which the HCP knows the answer, insisting on a show of knowledge (Anthonissen & Meyer, 2008:11-14), or even making use of roleplay as an attempt to elicit a response from patients (Anthonissen & Meyer, 2008:18-21).

Two discourse-oriented perspectives found in the literature are provided, namely "an interactional perspective and a pragmatic perspective" (Anthonissen & Meyer, 2008:9). They explain that from an interactional perspective, questions are used to link sections of discourse

²⁵ Cf. Byrne and Long (1976:39-41) for definitions and examples of the different types of questions found in doctor-patient communication.

in the sense that it often relates to previous pieces of discourse in the same interaction. Here they emphasise the fact that the addresser (or HCP) has the power to control aspects like topic development by asking specific questions (requiring a specific form of answer) related to previous or subsequent sections of discourse.

While the interactional perspective focuses on the relation between sequential orders of (question-answer) turns and the units of discourse preceding or following it, the pragmatic perspective focuses on the syntactic structure of a question in light of the specific answer it demands. Anthonissen and Meyer (2008:9) defines this perspective as one in which “questions are used to impose upon mental activities of the addressee”. The structure of a question aims to bring about a kind of cognitive search procedure in the hearer, bringing forth specific knowledge components. Bührig (2005:149) indicates that there is a connection between a speaker’s cognitive activities and speech activities, or utterances, and explains it in two ways. Firstly, the speaker can make use of specific linguistic means to guide the hearer in receiving and processing speech activities performed. Secondly, a speaker can plan an utterance, a process she calls “pre-history”, which precedes “performance”. In accordance, Auer (2002:1-3) believes projection to be involved in all adjacency pair formats and suggests that projection as a type (or part) of action has the power to prefigure another.

Rehbein (1984) reports on the kinds of questions in classroom discourse where a teacher sets a task for the students in which they must arrive at a particular answer by using specific mental activities. Stating a question can lead to alternate results: “the retrieval of adequate knowledge ... or to factual ignorance” of which the latter can take the form of an incorrect answer or silence (Rehbein, 1984:53). It is the way in which the question is stated that guides the hearer through specific knowledge paths in getting to an answer²⁶. These tactical questions have two parts (Rehbein, 1984:55). The speaker (i) provides contextual information as to the domain in which the required lacking knowledge can be found before s/he (ii) inquires about “the deficient domain of knowledge.” This first type of question has an “informative element” which serves a supporting role in prompting the students’ mental activities, whereas the second has an “interrogative element” which introduces the illocutionary act of asking a question (Rehbein, 1984:57). Scholarly reflection on how question-answer sequences are structured becomes relevant in this study for consideration of how counsellor questions in

²⁶ “[G]uessed knowledge” or attempts at answers would only be confirmed as “true knowledge” after feedback has been provided by the speaker. Additionally, “true knowledge” is “desired knowledge”, which in turn is confirmed as “correct knowledge” (Rehbein, 1984:55).

VCT are central characteristics of the conversation that check medical concerns, rather than specifically to check how well informed patients are about the prevention of HIV.

3.4.1.2 Information-giving sequences

In their study of addressing “dreaded issues” in HIV counselling, Peräkylä and Bor (1990) identify the interview approach to communication in counselling sessions as well as the informative approach. They state that the interview approach encourages the patient to articulate her/his own perspectives, fears and anxieties regarding what s/he will be faced with in the future. They further suggest that the informative approach is more one-sided even if unavoidable since it is protocol that VCT take an informative approach. Although the interview approach is important from a patient-centred point of view, in the context of this study it became clear that the counsellor is required to take an informative approach as well.

Coope and Metcalfe (1979:482) recall the origin of the word, “doctor” to mean “teacher” rather than “healer”. As discussed in section 2.4.3.1, the aim of pre-test counselling is to inform the patient of (among other things) the nature of the virus as well as the test to follow. The consultation should include the assessment of the patient’s understanding of the accompanying issues such as transmission and the development of the virus. In his study on post-test counselling, Green (1989:31-32) emphasises the importance of the counsellor’s responsibility to recognise the gaps or misperceptions in their patient’s knowledge and then to repair these areas.

Peräkylä (1995:48) describes the features of these statement-giving sequences of the counsellor as “independent ‘first acts’ that do not create a strong conditional relevancy for a particular type of ‘next’ to appear”. In saying this, he also notes that although these actions do not provide opportunities for the hearer to take the speaker role in response, it does not mean that the hearer does not in fact take the role of recipient in responding with collaborative hearer signals in an attempt to express her/his alignment as hearer. The speaker’s responsibility to constantly monitor the hearer for feedback within the joint focus is an important and generally overlooked feature of the consultation; the counsellor who has the talking turn needs to assess how the hearer is doing in uptake. This hearer (patient) feedback, in the form of verbal/nonverbal actions reveals whether the hearer is following, understanding, agreeing etc. It is the speaker’s responsibility to interpret these signals and adapt her/his actions if need be (Argyle, 1983:63).

Peräkylä (1995:57, *italics in original*) sums up by describing the way in which counsellors and patients organise two turn-taking parameters, as “*turn types*” and “*turn order*”. Where counsellors produce two turn types, questions and statements, patients only provide answers. Regarding turn order, he finds that patients’ turns usually follow that of the counsellor, after which the counsellor then either follows with another question or a statement. The formal schema he provides in this regard is adapted (in which *C* and *P* indicate the roles as counsellor and patient and *Q* and *St* indicate question and statement respectively) as follows:

[C:Q > P:A > (C:St >) C:Q] etc.

3.4.1.3 *Doctor-centred versus patient-centred behaviour*

Within a consultation, whether between doctor or counsellor and patient, a platform exists on which participants can influence each other by choosing specific communicative actions to address issues. Throughout the navigation of this process, participants employ different consulting strategies which, when used regularly, can be categorised in terms of behavioural styles (Pendleton, 1983:8). In reaction to Bales’ (1950) “interaction process analysis”²⁷, Byrne and Long (1976) identified seven behavioural styles a doctor can reveal through communicative actions that can be classified on a spectrum which ranges from doctor-centred to patient-centred. Wynn (1995:25) describes both Bales’ interaction process analysis and Byrne and Long’s system as a quantitative measurement providing a “behaviour or speech profile” and then provides ethnomethodological CA in contrast to offer a qualitative approach to analysing the same data, concerning itself with language use within different social contexts (Wynn, 1995:34). Regardless of the intention of the investigation, however, attention should be given to the structure of doctor-patient communication.

Medical consultations mostly tend to be structured according to a doctor-centred approach which reflects the traditional view of the doctor as the authoritative person responsible for the health of his patient. He takes this responsibility by guiding the consultation (Tate, 1983:75). Tate (1983:80) finds that in most cases the doctor “immediately go[es] down a form of clinical check list” at the start of the consultation. He explains that these set agendas are generally inflexible and rarely influenced by the behaviour of the patient (Tate, 1983: 76).

²⁷ Bales’ interaction process analysis is a coding scheme developed for “classifying direct, face-to-face interaction as it takes place” within small groups (Bales, 1950:5). He provides 12 categories within four groups into which each communicative act can be categorised. When applied to classify behaviour in doctor-patient communication, however, it proved to be “exceedingly general” (Heritage & Maynard, 2006:3), leading to the need to develop a contextually appropriate scheme.

Frankel (1984) reports on occasions in medical consultations where physicians utter curt minimal responses within elaborative talk from a patient with the aim of prematurely ending the patient's verbal contribution. In accordance, Tate (1983:81) mentions that doctors often – by making notes while patients talk – miss important nonverbal cues, in which contextual meaning is lost.

Heritage and Maynard (2006:6) list three significant matters over which the HCP has control within the consultation: the initiation of subject matter, the boundaries of its development, and the extent of patients' responses. Byrne and Long (1976:11) view the behaviour of the consulting doctor as “cause” and the patient's behaviour, conversely, as “effect”. On this note, Wynn (1995:43-52) touches upon the asymmetric distribution of power between doctor and patient, offering methods by which this power can be established and exerted (Wynn, 1995:44), as well as power models within the doctor-patient relationship (Wynn, 1995:49).

In their review of the advantages of using CA to study doctor-patient interaction, Drew et al. (2001) also relate to the way in which patient participation is shaped by doctors' choice in turn design. They (2001:61) state that in applying CA to the study of this discourse, one can see how “minor, detailed aspects of wording or phrasing in the design of a turn [can] have consequences for the sequential uptake by the next speaker”. They also, however, take care to mention that this is not necessarily the case in all consultations and give examples of opportunities created by the patient beyond the structural boundaries set out by this pre-allocated sequence in turn-exchange. This link between the doctors' or HCPs' choices of turn design as well as the opportunity for and features of patient participation supports the perception that doctors and HCPs have (and should have) control over the flow of the consultation.

In addition to navigating between interactional sequences, the patient and HCP each enters the context with their own schema and plan which conforms to their perception of the consultation. Mishler (1984) refers to the patient's agenda as her/his “lifeworld”, a type of personal background consisting of perceptions, attitude, and as in the case of VCT, possible anxiety and stress. The medical agenda of the HCP, on the other hand, is goal-orientated in that it aims to solve and treat the medical problem posed by the patient. Mishler (1984) views this inconsistency as conflict between the “voice of the lifeworld” and the “voice of medicine” and proposes a definition of “humane clinical practice ... that includes as essential

features the empowerment of patients and the centrality of lifeworld meaning” (Mishler, 1984:15).

Alternatively, patient-centredness is based on “[HCP] behaviour which is facilitating rather than dominating” (Stewart, 1984:174). Smith and Hoppe (1991:470) suggest that a patient-centred HCP prioritises the process of examining and understanding the patient’s concerns. They continue that the dynamics are contrastive to doctor-centred behaviour in that the patients guide the development of the subject matter and lead the general exchange which could distribute the power more evenly between participants. Medical consultations structured around a patient-centred approach are reported to result in higher compliance as well as better patient satisfaction (Stewart, 1984).

Where most doctors open a consultation with a set opening phrase, a patient-centred approach could be to listen in the first phase (Tate, 1983:80). HCPs are encouraged to take a more flexible approach like using open-ended questions (Tate, 1983:81). In this way, the patient can take charge in the areas where s/he is knowledgeable (introducing her/his lifeworld), while the HCP takes the floor on matters in which s/he is the expert (representing the voice of medicine) (Smith & Hoppe, 1991:470).

Striving to maintain a patient-centred approach is not only applicable to diagnostic medical consultations, but should, according to prescribed protocols and currently known experience, be a priority in VCT. The data in this study will show examples of interactions that exhibit features of the physician-centred approach (cf. chapter five). All recorded counselling sessions follow a course specific to each counsellor but at the same time generic in that counsellors clearly structure the consultation according to their prescribed “check list”. It has been suggested that doctors (or counsellors in this study) “learn a package of behaviours which seem to work in most instances [which] then appears to become ossified” (Byrne & Long, 1976:89). Kinnell (2002:374) also acknowledges this trend as he reports on the tendency of counsellors to only provide space for questions from the patient in the closing sequence of the consultation. He calls on counsellors to offer intermittent occasions for “a topic or activity shift” (Kinnell, 2002:374). Overly general questions in the form of “any other problems” or “anything else” are more prone to receive a “no” response and – when uttered in a counselling context – may indicate that the conversation is coming to an end (Kinnell, 2002:378).

3.4.2 Challenges in counsellor-patient communication

Aside from the potentially unequal balance of power and the debate between doctor- or patient-centred behaviour in this discourse, there exist many everyday influences that might threaten the success of communication in this context. It is important for counsellors to be aware of these possible barriers and how to overcome them. Challenges in counsellor-patient communication include the terminology used, cultural diversity, literacy, social class, emotion as well as having to communicate with patients who have varying first languages.

3.4.2.1 *Sophisticated terminology*

Medical terminology is seen as an “outstanding barrier” in HCP-patient communication (Korsch, Gozzi & Francis, 1968:862, cited in Gerber, 2013:126). As mentioned above (cf. 3.4.1.3), when HCPs and patients gather in interaction, the HCP’s “voice of medicine” comes into conflict with the patient’s “voice of the lifeworld” (Mishler, 1984). In this instance, Bourhis, Roth and MacQueen (1989:339, cited in Gerber, 2013:126) claim that HCPs are not only fluent in their “native everyday language”, but also “fluent in a highly specialised register, namely medical language”. As a stranger to the medical context, especially in this study, patients are fluent in the former, but not familiar with the latter (Bourhis et al., 1989:342, cited in Gerber, 2013:126).

Although they come from the same community as the patients, counsellors are trained to inform the patients of HIV through courses in which they were taught sophisticated biomedical jargon which is mostly not familiar to the lay patient. The majority of the counselling sessions in the captured data show clear examples of counsellors using jargon without inquiring as to whether or how much the patients understand. Furthermore, taking into consideration the pre-allocated turn system and consequential structural barriers provided by this institutional setting, one can assume that this type of discourse does not easily allow for patients to take the role of questioner themselves in order to ask for the clarification of possible confusion in this regard. Therefore, misunderstanding can occur without it being recognised.

3.4.2.2 *Cultural diversity*

“Disease ... occurs in a specific cultural context which determines how the illness will be identified, interpreted and managed” (Rousseau, 2005: 248) All acts of social interaction are a

product of two (or more) people. In this case, the HCP and patient, each with their individual cultural background, together with accompanying beliefs and perceptions of illness and the appropriate treatment (Rousseau, 2005:248) are required to achieve interactional success. Pendleton (1983:7) refers to a patient's perspective and assumptions regarding medical issues such as health, disease and treatment as the patient's "health understanding." Anthonissen and Meyer (2008:31) mention the importance of understanding "culturally determined taboos" that might make communication about subjects of a sexual nature (for instance transmission of HIV) difficult.

Rousseau (2005) reports on the development of context-specific clinical communication models in different countries (UK, USA, Australia and Canada) that address cultural diversity. Clinical care in these institutions is based on the clinicians' ability to identify every participating subculture in order to approximate the way in which their gathering might affect HCP-patient interaction. Van Dyk (2008:243) states that despite their differences, traditional healing and Western counselling find common ground within the counselling process. In this study, despite the fact that a single language is used to communicate, conversational participants do not necessarily have the same cultural background. Clinical communication in South Africa can certainly benefit from the training of HCPs not only to be sensitive to cultural diversity that goes beyond language divisions, but also to apply such sensitivity well in the consultations.

3.4.2.3 Literacy and social class

Regarding different levels of education and literacy among patients, it is important to be attentive to the fact that some patients might struggle to articulate their understanding of the virus, particularly given the fact that the required information has a complex biomedical nature. Regarding social class, Coope and Metcalfe (1979) set out to investigate patients' knowledge of health issues by collecting data through multiple choice surveys in doctors' surgeries. Their findings show a decline in the level of knowledge coinciding with the descending level of socio-economic class.

It is further found that during consultations with patients of a lower socio-economic status, doctors tend to communicate with less affection and offer less information regarding the diagnosis and treatment (Willems, De Maesschalk, Deveugele, Derese & De Maeseneer, 2005, cited in Gerber, 2013:128). Pendleton and Bochner (1980, cited in Tate, 1983:82) report

that general practitioners admit to offering less medical information to patients from a lower social class as they assume these patients do not have the need for it. Willems et al. (2005, cited in Gerber, 2013:128) further state that patients of a lower social class tend to have less communicative control in these conversations. They also, however, note that patients with lower socio-economic status usually approach the conversation with more reserved communicative behaviour than patients with higher socio-economic status, to which HCPs align and respond accordingly.

The participants in this study can be categorised as of low socio-economic status: they were inhabitants of rural areas, the majority did not complete secondary education, and all were working in the agricultural industry. Parallel to the patterns described in the literature mentioned above, is the patients' generally reserved communicative behaviour as conversational participants. This can be ascribed to many things from emotional stress to uncertainty that goes with the unfamiliar context. Feeling ill at ease often results in patients taking a passive role; some simply feign agreement with the counsellors in an attempt at speeding up the pre-test counselling session in possible anticipation of the test to come.

Implications of this kind of behaviour are particularly important in the given context. If the anxiety of a patient prevents her/him from voicing misunderstanding within the conversation, causing her/him to "let it pass" (House, 2003), it is highly likely that they leave the session poorly informed. Regardless of the outcome of the test that follows, the information that the patient was supposed to receive from the counsellor may not have been accurately received. This is problematic as the distribution of knowledge of HIV throughout rural communities is one of the first steps to addressing the epidemic. Furthermore, although counsellors give patients the opportunity to ask questions, these opportunities are not often taken up by the patient.

3.4.2.4 Emotional influences

In his research, Kalichman (1998:149) finds that receiving a positive result in HIV testing can be so traumatic for patients that they have difficulty in "retain[ing] information provided to them during post-test counselling". This distress can already be seen in the behaviour of the individuals in anticipation of receiving the results. Given the anxieties that go along with the process of VCT, as well as the unknown context to the individual, it can be expected that their behaviour will reflect their discomfort. Additionally, HCPs should be aware of the differences

in perspective between them and the patients regarding the meaning of the virus. Where the HCP might view HIV from a clinical point of view, patients facing it personally, might interpret the associated illness more emotionally.

It has been found that patients often seem reserved and that HCPs struggle to get patients to participate verbally. In his work on counselling, Gillis (1992:61) emphasises the importance of observing body language together with verbal behaviour. He urges counsellors to not only listen attentively, but to also observe actively, since meaning is often presented through nonverbal behaviour.

3.4.2.5 Multilingualism

With multiculturalism comes the issue of multilingualism. Here, reference can be made to section 2.8.1 where “unproductive patient-provider interactions” or “dysfunctional consultations” are introduced. Studies show that (especially in a multilingual South African context) doctors are aware of such possible misunderstandings as well as the risk of misinterpretation or loss of information along the linguistic barriers. Deumert (2010:58), for example, reports on doctors pointing out that receiving a positive response from a patient does not always mean that they have actually understood the information.

In order to avoid communicative difficulties in multilingual settings, HCPs should be trained firstly to accept the inevitability of miscommunication at any time during the conversation and secondly to handle and repair awkward moments and difficult conversations when they occur (Epstein, Morse, Frankel, Frarey, Anderson & Beckman, 1998:441). HCPs should further be able to recognise patients’ difficulties in following the language of consultation, especially when they signal this by resorting to alternative resources to complement (broken) language (Roberts et al., 2005:474). Epstein et al. (1998:441) consider necessary skills for HCPs in multilingual communication to include the ability to discuss and work through awkward situations or subject matter, to elucidate any problematic language for the patient and to tend to the patient’s perceptions, fears and anxieties. They also recommend the use of simple clarifying statements or redirecting statements to help in this process.

3.5 THE STUDY OF HEARER SIGNALS

In their seminal work on Speech Act Theory, Austin (1962) and Searle (1969) drew attention to the importance of studying instances of articulated code within the social context where it

is produced. Their work contributed to the recognition of the role of context in meaning-making. This implicitly criticised a position which attempted to isolate knowledge of language from other kinds of knowledge in trying to make sense of semantic features of language. It motivated scholars turning attention to often unstable supplementary semantic phenomena such as “expressive, paralinguistic and kinesic features” (Goffman, 1964:133). In the same vein Clark (1996) mentions that methods of signalling – where a signal represents any action carrying meaning within a conversation – can be linguistic or non-linguistic. Verbal and nonverbal speech acts go together to form meaningful interpretable messages (Kendon, 1980) and by trying to define language without considering its sociolinguistic circumstances as well as accompanying gesticulation (Duncan, 1980:127), our understanding of the way in which language “succeeds as an instrument of communication” may be incorrect (Kendon, 2000:62).

The presence of nonverbal signals concurrent with speech might affect speech in that a message can be articulated less explicitly than its written counterpart, since in face-to-face conversation, gestural, facial, and prosodic acts can influence meaning or interpretation (Linell, 1982:6 cited in Bavelas & Chovil, 2000). With regards to its contribution in linguistic tasks, Kendon (2007:25) refers to gestures as “vehicles for the expression of thoughts” in that they co-create a speaker’s message. Slama-Cazacu (1976:218) elaborates by stating that gestures complement, and might even substitute concurrent verbal communicative behaviour in speech. Research further suggests these two components of conversation to be integrated and interdependent (Birdwhistell, 1966:183; McNeill, 1992:2). Their coordination is “governed by a complex set of rules and mechanisms” of which participants have an inherent, instinctive understanding that is a prerequisite for everyday face-to-face interaction to take place efficiently (Wynn, 1995:13).

Heath (1986) emphasises the important (and sometimes overlooked) role of movement in interaction. He claims that movement – in the same way as speech – has a social function in that it carries out action and activity that occur in, and are dependent on some kind of social organisation. It is within its situational setting that participants in interaction can produce and interpret movement (Heath, 1986:18).

Clark and Carlson (1982:332) mention that “[a]lthough hearers play an essential role in speech acts, that role has never been fully examined”. Rosenfeld and Hancks (1980:193) shed light on the fact that although the speaker is widely assumed to be the main information

provider, the listener definitely does not merely take a passive role in receiving this information. Linell (1982:6) emphasises the hearer's active participation saying that "the listener responds all the time".

3.5.1 The hearer as co-participant in conversation

Initially, communication was perceived to be autonomous in that communicative activities were believed to be carried out by the speaker alone. This unidirectional perspective of communication confines the interactional process to one in which participants are taken to be either sources (speakers) or destinations (hearers) (Kraus et al., 1977:523). The importance of the hearer has since, however, been highlighted: "[t]he very notion of [the speaker's] meaning requires addressees to join speakers in a special way ..." (Clark, 1996:125). The collaboration between speaking and listening from a bilateral perspective requires a speaker to not only observe her/himself ("self-monitoring"), but to observe the hearer ("other-monitoring") in judging the success of interaction. Both participants have to take each other's actions into account (Clark & Krych, 2004:62).

As soon as two or more participants initiate communicative interaction, Goffman (1963:95) suggests that they maintain "an eye-to-eye ecological huddle" in which they can monitor each other. For communication to be successful, Streeck and Knapp (1992:20) suppose that participants need to continuously maintain this mutual presence and understanding by means of fulfilling specific behavioural roles within conversation (cf. 3.2.4). Accompanying these interactive roles, two perspectives on one mutual goal are found. While the listener's goal is to successfully interpret and understand the "goals and meaning" of speech acts received, the speaker's goal is to facilitate the goals of the listener, aiming to assist in the efficient development of the listener's interpretive processes (Burlison, 2011:31).

From a constructivist perspective, Burlison (2011:27, *italics in original*) defines listening as a "*process that involves the interpretation of messages that others have intentionally transmitted in the effort to understand those messages and respond to them appropriately*". He (2011:32) identifies six steps that are employed during the listening process. The hearer (i) becomes aware of a communicative action produced by a speaker to convey a message. This communicative action, or signal, (ii) is perceivable in the form of words and phrases (or other nonverbal communicative actions) and represents what the speaker is (iii) saying (inferred through syntactic analysis), (iv) meaning (inferred through semantic analysis), (v) doing

(inferred through pragmatic analysis), and (vi) aiming to achieve (inferred through motivational analysis).

As opposed to telephone conversations, participants in face-to-face interaction have access to audible as well as visible resources in the ongoing process of maintaining mutual understanding (Bavelas & Gerwing, 2011:180). Throughout this process, the hearer provides the speaker with feedback in the form of verbal or nonverbal hearer signals. Rosenfeld and Hancks (1980:193) state that these frequent signals are primarily produced by the hearer in reaction to what is being said by the speaker, and that it is not an attempt to take the floor. Below follows a definition of this phenomenon of hearer signalling, together with a review of literature that describes its functions, forms and contribution in face-to-face interaction.

3.5.2 Defining hearer signals

Inconsistencies in research regarding the title and definition of hearer signals abound (Gardner, 2001:13). As early as 1952, Fries set out to categorise utterances in order to describe the different kinds of sentences used in spoken discourse. He defines hearer signals as “single free utterances” (or head nods) that conventionally provide feedback to the speaker regarding her/his ongoing attention to the speaker’s talk (Fries, 1952:49). These signals have also been called “concurrent feedback” (Krauss & Weinheimer, 1966), “accompaniment signals” (Kendon, 1967), “acknowledge acts” (Sinclair & Coulthard, 1975), “minimal responses” (Bennett & Jarvis, 1991; Felleggy, 1995; Stubbe, 1998), “listener responses” (Dittmann & Llewellyn 1967, 1968; Kraut et al., 1982; White, 1989; Bavelas et al., 2002; Xudong, 2008), “acknowledgement tokens” (Jefferson, 1984; Drummond & Hopper, 1993), “reactive tokens” (Clancy et al., 1996; Young & Lee, 2004), “response tokens” (Gardner, 2001) and “affirmative responses” (Hirschman, 1994 [1973], cited in Gardner, 2001).

Bublitz (1988:160) identifies “hearer signals” as an example of a participant in the hearer role’s “right to speak at any time”. Together with specific reactive or “recipient” contributions (1988:141), he defines hearer signals as the verbal and nonverbal signals (or “conversational objects” (Gardner, 2001:13)) that a hearer produces to acknowledge reception of a speaker’s information with the goal of confirming that s/he is in fact the listener (Bublitz, 1988:169). The speaker can then interpret these signals as discourse information on the way the interaction is progressing (Gardner, 2001:13). By providing a definition that focuses on its production location, Yngve (1970) coins the term, “back channel”. While the “main channel”

is occupied by the speaker, the back channel is open for the hearer to produce non-interruptive responses (Bavelas, Coates & Johnson, 2000:942).

As previously discussed, an interactional participant in the hearer role is not a passive member of the dyad, but regularly provides feedback to the speaker. Theoretically speaking, by producing speech in the form of a hearer signal, regardless of whether an utterance's intention is to take the floor, a hearer briefly becomes the speaker by verbally providing a signal to the speaker. Considering the uncertainty in much of the literature regarding what constitutes a hearer signal, the view this study takes on when a patient is a speaker and when a listener giving a signal, is given as follows.

As explained above, hearer signals are actions made exclusively by the hearer throughout the period in which s/he is in the role of the recipient of speech acts. It is important, in this regard, to distinguish between a hearer simply providing input while remaining in the hearer position, and one exchanging the interactional role. When a current speaker initiates a first part of an adjacency pair, for instance, by asking a question, the answer provided does not constitute a hearer signal; rather it is a contribution from the hearer who has taken the speaker role that was awarded to her/him. The initiator of the exchange relinquishes the speaker role in an attempt to complete the initiated speech act sequence. Throughout this study, care has been taken to distinguish between on the one hand responses like "yes" and "hm" that exist as a second part in an adjacency pair, and on the other hand the same utterances produced as hearer signals with different functions. Depending on where and how the utterance is placed contextually, such an utterance offers different contributions from the hearer's side.

Another way to determine the status of an utterance as either a hearer signal or a new speaker turn, is to analyse the way it is treated by the participants (Schegloff, 1982:92). A clear marker of hearer a signal as such, lies in the way participants treat them. According to Bublitz (1988:185, italics in original) hearer signals are "neither topic-holding nor content-holding" as they are generally not referred to or commented on throughout the interaction (with a few notable exceptions). In this study, any possible hearer signals to which speakers specifically reacted were identified as a different kind of contribution to the conversation and thus excluded as 'hearer signals'. In this way, although some researchers claim that (e.g.) requests for clarification can be categorised as hearer signals (Yngve, 1970:574; Duncan & Fiske, 1977:201-202), they are not taken as such because they are produced with the aim of

prompting a response. This study follows Schegloff's (1982:91) opinion in categorising these types of requests as a speaker contribution.

Other utterance types about which there are varying opinions are sentence completions and "[b]rief restatement[s]", both of which Duncan and Fiske (1977:201-202) include as hearer signals. What is apparent in the data of this study, however, is the fact that a clear distinction cannot be made without considering the utterance within its linguistic and situational context. An important feature of the meaning of these kinds of utterances is that it is intuitively, pragmatically and contextually determined. In this case, each restatement and sentence ending offered as a possible phrasal hearer signal was considered within its context in which an interpretation was made according to the way in which the participants respond to it.

On this point, Yngve (1970) comments on the difficulties regarding the interpretation of the turn status of utterances in the analysis of conversation. He finds that each participant experiences and interprets the development of the conversation and the taking and managing of turns according to her/his own perception, which does not necessarily coincide with the perceptions of the other. In this way Yngve (1970:568) "account[s] for the difference in a person's behavio[u]r between when he thinks he has the turn and when he thinks he [does not]". The fact that participants in conversation themselves are not always aligned in their perception of the distribution of speaker and hearer roles can thus additionally complicate the observer's judgement.

3.5.3 Features of hearer signals

Schegloff (1982:92) establishes the function of speech activities such as "yes" and "mhm" on the basis of the location of the signal, as well as the surrounding discourse and wider communicative context. A first feature of hearer signals is thus their location within the speaker's utterance. Dittmann and Llewellyn (1967:342) find that the majority of spontaneous verbal listener responses are located at speakers' phonemic "boundary points" or "junctures" and very rarely occur earlier within a speaker's phonemic clause. These junctures might be used by the speaker for "planning" or "breathing" throughout speech (Bublitz, 1988:183).

On this note, it is important to consider different cultures' viewpoints regarding the appropriate number and kind of verbal and nonverbal hearer signals (Stubbe, 1998). Xudong (2008), reports that there are more listener responses (mostly placed at possible phrase or sentence endings) in Australian English as opposed to Mandarin-speaking Chinese

interlocutors who produce less listener responses, tending to place them throughout a speaking turn. Also comparing Western and Asian cultures, White (1989) and Maynard (1986, 1990) find that Japanese hearers make use of several types of listener responses much more frequently than American English speakers do.

What further distinguishes hearer signals from other hearer contributions that could serve as attempts to take the floor, is the fact that hearer signals that overlap with the primary speaker's utterances are not dealt with as interruptions (Bublitz, 1988:184). These overlapping hearer signals can occur expectedly or unexpectedly and can or cannot be elicited by the speaking participant (cf. 3.5.5.3 for a discussion of the ways in which speakers can influence the production of hearer signals) (Bublitz, 1988:182).

Regarding their form (cf. chapter six for the elaboration on and analysis of hearer signals found in this study), verbal hearer signals are usually short and monosyllabic like “hm”, “yeah”, and “uhuh”, together with longer phrases such as “I understand”. Their intonation is usually lower than the nuclear tone of their preceding utterance, and they generally either have a falling or level tone (Bublitz, 1988:184). As noted below, nonverbal hearer signals also occur in the form of head nods and facial expressions. Verbal and nonverbal hearer signals can be produced in isolation or simultaneously to the speaker's contribution, and can carry similar meanings either way.

3.5.4 Functions of hearer signals

The production of hearer signals enables the listener to make sure that a speaker is continually informed about her/his current level of understanding (Clark & Krych, 2004:73) and can make various kinds of contributions to the conversation. With this being said, the production of a hearer signal does not necessarily reflect the hearer's level of attentiveness, as it is quite possible (and not inconceivable) for a hearer to automatically produce hearer signals even if he is not following, understanding or interested (Bublitz, 1988:172). Hearer signals “at best *claim* attention and/or understanding, rather than *showing* it or *evidencing* it” (Schegloff 1982:78, italics in original).

3.5.4.1 *Continuers and assessments*

Hearer signals most commonly take the form of “continuers” that aim to signal a hearer's acknowledgement of a speaker's state of speech (Schegloff, 1982). To elaborate, a hearer

produces continuers (such as “uh huh” and “mm hm”) at potential turn-transitional locations within a speaker’s speech structure in order (i) to acknowledge ongoing incomplete extended speech, (ii) to encourage the speaker to continue and finish the discourse unit, and (iii) to declare that s/he will not be making claims to the opportunity of the current potential speech turn (Schegloff, 1982; Gardner, 2001:14). Jefferson (1984:4) states that continuers taking the form of “mm hm” are usually used to display “passive reciprocity”, whereas signals like “yeah” display a hearer’s willingness to take the floor. In this instance, hearers refuse to either produce their own extended speech turn or to attempt a repair on preceding speech received (Goodwin, 1986:207). In short, these signals can serve as cues that a listener provides for a speaker in giving him/her feedback about his “pacing, clarity and success at exposition” (Schefflen, 1975:68).

Short verbalisations such as “oh” or “wow” can be used in assessment of the content of the speaker’s utterance, assessing the information as e.g. significant or noteworthy (Goodwin, 1986), to which Gardner (2001:14) ascribes the term “newsmakers”. Since these signals are not used as intersentential acknowledgers in that they link two pieces of discourse together, Goodwin (1986) distinguishes between “continuers” and “assessments”. While both types of hearer signals contribute to the unfolding of a speaker’s extended turn, the former focuses on the spoken utterance with which it overlaps and treats it in anticipation of following speech, while the latter is affiliated with the current speech turn in isolation of what is to follow.

Another distinction between continuers and assessments is their location within speech. Continuers are mostly produced across the boundaries between two consecutive speech units and meticulously collaborate in achieving a transition by overlapping the last syllable(s) of a speaker’s first turn-constructive unit, and possibly also overlapping the first syllable(s) of the speaker’s following utterance (Goodwin, 1986:208). An example from the data collected in the study and given in the excerpt below illustrates this. The key to abbreviations used in transcription excerpts is given in chapter four (section 4.6) below.

	138 [03:53.2]	139 [03:55.8]	140 [03:56.6]	141 [03:58.4]
C[v]	• ons gee vi' jou • uh vitamien pillie, nè?	• net	om te jou liggaam sterk hou • nè?	
C[FP]	<i>ons gee vir jou</i>			
C[ENG]	• we give you • uh vitamin pillss,	right? • just	to keep your body strong • right?	
P[v]		Okay'		Ja'
P[ENG]		Okay'		Yes'
P[SUP]		softly		whispering
P[NV]	<i>nodding'</i>			

At the phrasal juncture in the excerpt above provided in interval 139 of the counsellor's speech, the patient provides a hearer signal, "Okay", that overlaps with (i) the last word ("nè?") from the first phrase, is articulated through the short natural pause provided by the speaker, and overlaps with (ii) the first word ("just") of the following phrase (140). Although they are not always found to overlap speech in this way, Goodwin (1986:207) calls continuers "bridges between units".

As assessments are solely interested in commenting on the semantic content of a spoken utterance without reference to following discourse, they are usually produced and completed within the boundaries of the speech with which they are affiliated (Goodwin, 1986:209).

3.5.4.2 Acknowledgers and receipts

Regarding content, hearer signals take the form of acknowledgers in reacting to received information, i.e. acknowledging understanding, showing agreement or indicating that the information is newsworthy (Gardner, 2001:13; Schegloff, 1982:78). They can also be used by a participant to acknowledge receipt of information (Schiffrin, 1987:95). Bublitz (1988:175-176, upper-case in original) provides a possible equivalent of these hearer signals to convey something like "I am CONFIRMING that I am (or have been) taking note of what you are (or have been) saying (and what you mean or have meant)." Along the same lines, these signals are used to show acceptance of shared information and indicate that the hearer judges a speech action to be contextually relevant, and that the interests and attention of the speaker and hearer are aligned (Bublitz, 1988:174, 195).

3.5.4.3 Personal expression

Hearers have been found to use modal conversational signals in order to "express their expectations and suppositions regarding the social relations and common knowledge with the other participants, their attitude in relation to the content of the utterance, or their wish to influence others' behaviour" (Rodrigues, 2008:215). Moreover, hearer responses such as "yeah" can comment on contextual informality (Bennett & Jarvis, 1991) and can serve to indicate shared knowledge or alignment between participants (Lambertz, 2011). Wynn (1995:43) states that hearer signals can be produced to illustrate interest in, or attitudes towards (Gardner, 2001:14) a speaker's speech action.

By providing particular hearer signals, and specifically in the manner of production, hearers can indicate their position towards what is being conveyed. If a hearer, for example, utters a surprised “oh” as a signal, this will indicate that s/he is attentively listening and interested in what is being said. Less animated vocal hearer signals or head nods, on the other hand, can indicate that a hearer is distracted or disinterested and is only superficially going through the expected motions of providing hearer signals throughout another’s speech.

3.5.4.4 Hearer signals that influence the speaker

Given the variety of hearer signals to choose from, Schegloff (1982:85) suggests that producing variations of hearer responses in succession throughout ongoing speech is a way of showing interest, whereas uttering the same hearer signal in a series of about four or more might be a way of hinting at what he calls “incipient disinterest” from the hearer. This kind of behaviour, as well as a decrease in verbal and nonverbal feedback from listeners tends to result in turn-endings and speaker changes (Wynn, 1995:43).

On a structural level, hearer signals can also have an impact on the turn-taking process as listeners play a role in the regulation of appointing a (next) speaker (Schefflen, 1975:67). Here, hearers can implicitly select the next speaker by shifting their attention towards a specific person. This can be done simply through gaze, or by shifting the body to face a participant. A hearer signal such as the display of reciprocity can also be used to encourage another participant to produce some kind of speech action. This phenomenon is given more attention overleaf.

3.5.4.5 Display of reciprocity

As a communicative signal that should not be overlooked, gaze also has a number of functions within face-to-face interaction. While “eye-to-eye looks” are used in the instigation of interaction (Goffman, 1963), gaze – as well as head movement (Duncan, 1972) – play a role in the exchange and management of interactional roles and turn-taking (Kendon, 1967). An interesting way in which the shifting of gaze can be used by a potential receiver of information as hearer, is to display her/his readiness to receive speech (Heath, 1986).

In his study of body movement and speech in medical interaction, Heath (1986:26) discusses the ways in which patients use gaze to either “initiate or progress action and activity within the medical consultation.” Within the discourse structure of medical consultations, it is

common for patients, following their arrival, to wait for the HCP to familiarise her/himself with the necessary medical documentation. During this waiting period, participants find themselves in “an environment of free-floating opportunity”, in which both participants could have taken the floor at any time they might deem appropriate (Heath, 1986:28).

In many of these situations the patient then displays her/his reciprocity non-vocally, by either a shift in posture or gaze. The moment a patient then shifts her/his posture, gaze, or both towards the HCP, the HCP reacts by initiating speech or starting the business of the consultation. By producing this kind of movement action, Heath (1986) suggests that the participant challenges the environment of free-floating opportunity by creating a situation in which the HCP is encouraged to produce some kind of action in turn. “Through a display of reciprocity an interactant may show that he is ready and prepared to receive an action or activity from another person” (Heath, 1986:29). This action can also be used during an already established conversation in which it can be employed to repair a disconnection of speech, for instance (Heath, 1986:31).

3.5.5 Forms of hearer signals

After shedding light on specific functions of hearer signals, it is necessary to review literature of the forms that these signals take. This section lists different types of hearer signals; first, verbal utterances provided via the back channel and second, nonverbal hearer signals which include head nods and gesturing.²⁸ On this topic, the influence that the speaker has on the hearer’s production of back channels will also be accounted for.

3.5.5.1 Verbal responses

Hearer signals, as has been mentioned, are short messages produced by the listener in interaction without attempting to take the speaking turn. These frequent non-interruptive responses aim to reveal understanding as well as various states of the hearer’s being, for instance showing enthusiasm, agreement, interest, and so forth. By monitoring the hearer, the speaker can then interpret these signals in her/his evaluation of the success of her/his communicative performance. Although verbal hearer signals can take the form of longer speech phrases, they generally take the form of short word utterances such as “okay”, and

²⁸ Facial signals such as smiles can also serve as hearer signals (cf. Ekman, 1993, 1997; Brunner, 1979; Goodwin, 1984; Fridlund, 1991; Chovil, 1991, 1991-1992). Due to the additional complexity of recording and connecting such signals to the larger discourse, this study does not attend to them.

“yeah”, or non-speech verbal utterances such as “mhm”. Duncan and Fiske (1977:201) also state that these can be uttered once, or be repeated, for instance “yeah yeah”.

A prominent piece of listener feedback that has received attention is the term “okay” which can be uttered in reaction to previous talk or in orientation to a following utterance by both hearer and speaker. While a speaker might use it as a filler, the hearer utters it for many reasons (Beach, 1993). In a freestanding (or “non-continuative”) manner, “okay” can serve as an acknowledgement or indication of understanding in response to what has been projected by the speaker’s prior utterance. Within unfolding talk “okay” has a dual purpose as a reaction to prior utterances (having a “responsive” purpose), while also setting up an opportunity for following utterances (“preparatory” purpose, by potentially initiating a topic shift) (Beach, 1993:338). This short response can additionally be used in the same way as “oh” is used as an acknowledgement of discovery or reception of new information (Heritage, 1984). It can also be used as a newsmaker (Gardner, 2001:14) and can function on a structural level by providing a finality used to project a potential ending in transition (Beach, 1993:342).

“Yeah” and “mm” are the most widely used hearer signals (Rosenfeld & Hancks, 1980:194). Both these short vocalisations are used as continuers, assessments and acknowledgers and can overlap with speech in representing alignment and agreement. While “yeah” is reported to show interest or to encourage another participant, “mm” has been found to carry a more neutral disposition (Lambertz, 2011:13). Regarding alignment, hearers use “yeah” more commonly than “mm” to indicate a shared thought or opinion (Lambertz, 2011:14-15). As will also be evident in this study, these hearer signals can often be ambiguous in that their functions in particular instances are not necessarily unambiguous and clear.

3.5.5.2 *Head nods*

Head nods as a type of body movement generally occur throughout conversation, even within utterances of talk. The head nod is identified as the most common kinesic form of hearer signal and can be seen as the nonverbal equivalent of the brief vocalisations described above (Rosenfeld & Hancks, 1980:194). These signals can be produced at the same time (or combined with longer verbal back channel utterances), or independently from each other. In the light of their similarities, studies have been conducted that investigate the relationship between the two phenomena, namely verbal and kinesic hearer signals.

Head nods, for instance, are found to occur simultaneously to short vocal responses too often to be random (Dittmann & Llewellyn, 1968) and in these cases, they often precede their vocal counterpart (Dittmann & Llewellyn, 1967). Moreover, head nods often occur at times when speaker and hearer jointly interact with each other, which is why they are considered a “marker for units of social interaction” during which participants are more closely focused on each other (Dittmann & Llewellyn, 1968:82). Head nods can also – the same as with gaze – be used to signify the speaker’s readiness to receive feedback, as well as the listener’s readiness to take the floor.

Rosenfeld and Hancks (1980:194) identify the difference between head nods and short vocalisations as back channel listener feedback in a similar way to Dittmann and Llewellyn (1968) in terms of timing. In comparison, listener head nods occur early more frequently throughout a speaker’s utterance than vocalisations which tend to occur around the end of an utterance. The reasons for this might be because (i) head nods provide feedback that is minimally intrusive to speech as opposed to the overlap of speech, and it might indicate that (ii) the listener is decoding the speaker’s message faster than it is being encoded, which could affect the quality of the speaker’s following messages (Rosenfeld & Hancks, 1980:194).

Heath (1986:15) provides an example in which a hearer produces a head nod with the aim to encourage the speaker to continue her/his turn in an instance of silence within a speaking turn. He then finds that this hearer signal is successful in its goal as the recommencement of the speaking turn is a direct reaction to its production. In the example he provides, however, the role of speaker is being filled by the patient, and hearer by the doctor. Despite the role reversal in this study, where patients are largely in the hearer position, the same outcome can be anticipated since the turn-taking system requires both participants to switch through both roles continuously.

3.5.5.3 The speaker’s influence on hearer signals

According to Bublitz (1988:142) “[t]here are means with which [the speaker] can not only establish a relation to the following reaction of the hearer but also restrict the scope of the latter’s action drastically, so that he feels compelled to act in accordance with the options provided by the speaker”. It has been estimated that about half of the occurrences of listener feedback are prompted by some kind of speaker-produced cue (Ward & Tsukahara, 2000).

Specific actions on the side of the speaker, for example a long gaze, can solicit a type of response that shows attention, as e.g. a head nod (Schegloff, 1982:79).

On a prosodic level, speakers have been found to indicate their readiness to receive feedback from hearers through low-pitched parts of utterances (Ward, 1996; Ward & Tsukahara, 2000). Although speakers are not necessarily consciously aware of it, the occurrence of speech on a low pitch can elicit feedback in that it aids the listener in calculating when to produce feedback which is in accordance with the findings that hearer signals occur almost exclusively at the end of a speaker's phonemic clause (Dittmann & Llewellyn, 1967). Another example in which speakers use prosody to prompt a response from the hearer is where they utter a statement with rising intonation towards the end, typical of a question sentence (Lambertz, 2011). In mimicking the intonation of a question produced as the first part of an adjacency pair, this intonation change can serve as a request for a hearer response. This is then followed with a token of agreement, "yeah" (Lambertz, 2011:15). Similar articulation techniques employed by the speaker include constructing speech in such a way that it "invite[s] some sort of 'reaction'" (Schegloff, 1982:85), stress and especially stretched sounds and drawn out conjunctions to which hearers usually respond with a signal (Goodwin, 1986:211-212).

Apart from prosodic and narrative cues, speakers make use of verbal feedback requests throughout talk. These kinds of requests (like "y'know") can function as attention-drawing devices (Schiffrin, 1987:282) and although they are used so often during speech that they could be interpreted as "verbal tics", their presence often successfully serves as a request for feedback from the hearer. Also, they are mostly responded to nonverbally with a head nod (Dittmann & Llewellyn, 1968:83-84). Bublitz (1988:142) calls these types of influenced questions requesting agreement "performance phenomena".

Gaze is also used by the speaker to influence reactions and responses from the hearer (Kendon, 1967). Bavelas et al. (2002) confirm this in their pursuit to uncover the effect that eye gaze has on the listener responses occurring when they do. By comparing the gaze of speaker and listener, they find that the listener maintains a fixed gaze on the speaker for a longer period of time than the speaker who focuses her/his gaze on the hearer for shorter amounts of time. The "gaze window" is the brief moment before speaker change occurs during which the speaker shifts her/his gaze toward the hearer, which results in mutual gaze (Bavelas et al., 2002:569). They add that throughout prolonged instances of speech this

phenomenon will more often than otherwise result in the production of some kind of hearer signal.

3.6 CONCLUSION

This chapter gave an overview of the scientific field of Linguistic Pragmatics as well as a theoretical framework based in this area of research and aimed at analysing and understanding talk-in-interaction. In order to contextualise the nature of the type of conversation that will be analysed in chapters five and six, literature on the structure and features of medical discourse as a conversation genre was provided, as well as attending to hearer signals as a kind of utterance found in these conversations. The preceding chapter provided the background required to understand the situational context of this study and the following chapter will introduce the methodological approach taken in this research.

Chapter Four

METHODOLOGY

4.1 INTRODUCTION

This study is a qualitative research project situated within the area of Linguistic Pragmatics in which an interest in (i) discourse markers used by listeners in a conversation and (ii) specific generic characteristics of conversation determine the methodological approach. Using Corpus Linguistics, hearer signals and their communicative functions are identified. CA with its focus on the sequential ordering of spoken language, is used as theoretical framework in characterising HIV pre-test consultation. Detailed examinations of the conversations of a small number of participants aim to provide a naturalistic description and interpretation of institutional talk in interaction in the form of counsellor-patient communication within the medical context of VCT in HIV care. In outlining the methods used, this chapter will give an exposition of the context in which this study is located and then provide a detailed description of its participants. The process of data gathering will be described with focus on the instruments that were used as well as the subsequent processing and analysis of the data in the form of an archival analysis and case studies.

4.2 CONTEXT

Data were collected from two day care clinics in rural towns in the Winelands district of the Western Cape. Clinic A operates in a town that has no hospital; it is situated within an informal settlement area outside the town's centre. The closest full medical facility for this community is in a larger neighbouring town 34 km away. Clinic B is situated on the same premises as the public hospital of the town; it is close to the town centre and not necessarily as accessible to patients from the town's informal settlements. Twenty HIV pre-test counselling sessions were recorded at clinic A of which six were conducted in Afrikaans, eight in isiXhosa, three in English, two in which an interpreter was used to translate from isiXhosa (from the counsellor) to Sesotho (to the patient), and one case of a Shona L1 speaker with rudimentary English who – after a two-minute attempt in English – could not be

accommodated. Twelve sessions were recorded at Clinic B of which eight were conducted in Afrikaans, three in isiXhosa and one in English.

The language in which the consultation was conducted, was negotiated (implicit or explicitly) between counsellor and patient depending on the language repertoires of each. More observations were recorded at Clinic A than Clinic B due to its location in close proximity to where large numbers of state supported patients live with no alternative clinic for HIV-testing. Clinic B is not the only clinic in the particular town and since the majority of the target group resides in the rural informal area outside the centre of the town lacks mobility, one can assume that clinics closer to their place of residence would be better attended.

The data collection was done during a time in which seasonal workers from different provinces as well as neighbouring countries were working on farms in the region. Such migration is regular during the harvesting time since the primary agricultural and economic activity in both these towns is fruit farming. The majority of the migrating workers are citizens of Lesotho and Zimbabwe whose L1s are predominantly Sesotho and Shona respectively. These foreign workers bring a larger degree of linguistic diversity to the clinics than just the local languages, so that the interactional data illustrates a variety of forms of intercultural and multilingual communication. The data eventually represented speakers with L1s ranging between Afrikaans, isiXhosa isiZulu, as well as Sesotho and Shona. Although all participants had some level of L2 English proficiency, none were L1 English speakers. In spite of the linguistic diversity of the full population whose consultations were recorded, the majority (72%) were L1 speakers of Afrikaans (44%) and isiXhosa (28%).

4.3 PARTICIPANTS

Although, as stated above, a number of multilingual sessions were recorded in which counsellor and patient had different linguistic repertoires, only the sessions conducted in Afrikaans were selected for analysis in this study. This selection was motivated by the consideration that to investigate hearer signals thoroughly the number of variables had to be limited. The decision was to first investigate such signals in an Afrikaans linguistic context as the larger part of the observed consultations were conducted in Afrikaans. A comparative study would require a different approach and more data on consultations in the lesser represented languages or in interpreted sessions. The assumption I work with is that when the L2 of patients is used (as when English is the language of consultation) or in interpreted

consultations (as when a Shona:English interpreter mediates between a Shona L1 patient and an English L2 counsellor) hearer signals will be different in form and function to those used when the L1 of patients is the language of the interaction. For example, a head nod simultaneously produced with a given phrase in Afrikaans may have a different communicative function to a head nod simultaneously produced with a similar phrase in English or in an interpreted interaction. Observations of the full complement of the data from Clinics A and B confirmed this as a reasonable assumption. For this reason, only data collected during the Afrikaans consultations have been used in this study. Even so, all the recorded sessions, as well as the associated metadata have been documented and saved for follow-up work where a comparative study can be undertaken. Table 4.1 below gives a summary of the full set of participants across both clinics, indicating which L1s were represented among them. The set of consultations that were conducted in Afrikaans is made up of six at Clinic A and eight²⁹ at Clinic B – thus a total of 14 cases.

Table 4.1: Language used in counselling session according to L1 of patient

Language identified as L1 of patient	Afrikaans L1	isiXhosa L1	Sesotho L1	Shona L1	isiZulu L1	English L1	Total
Clinic A	6 30%	6 30%	4 20%	4 20%	0 0%	0 0%	20 100%
Clinic B	7 58.33%	3 25%	1 8.33%	0 0	1 8.33%	0 0%	12 100%
Total	13 40.62%	9 28.12%	5 15.62%	4 12.5%	1 3.12%	0 0%	32 100%

As discussed in section 2.6, the predominant home languages in the Western Cape are Afrikaans (49.7%), isiXhosa (24.7%), and English (20.3%) (Statistics South Africa 2012a:25). English is widely distributed as an L2; as an L1 it is more commonly found in urban areas. In deciding on the language of the consultation, limited proficiency in English

²⁹ The discrepancy between the number of Afrikaans sessions (eight) and the number of L1 Afrikaans speakers (seven) in clinic B as indicated in table 4.1 is due to one Afrikaans session in clinic B being conducted with an L1 speaker of isiXhosa who had native speaker level Afrikaans proficiency.

was not a problem for South African patients at the clinics since they were mostly accommodated in their L1. The only counselling sessions that were conducted in English, were those of Zimbabwean patients who make up 20% of the patients at clinic A. Where patients could not be accommodated due to the lack of a lingua franca between them and the HCP, interpreting has to be considered. However, due (also) to the wide distribution of L2 English this is a rare occurrence so that there is no systematic provision of interpreting services. Only one such event occurred across the 32 consultations recorded for this study when an L1 Shona Zimbabwean was not conversant enough in English so that an alternative arrangement had to be made. Usually when this occurs, the clinic (i) makes use of a staff member who can speak the L1 of the patient (as with e.g. Shona), (ii) calls in an informal interpreter from among the other waiting patients, or (iii) asks the patient to come back later and bring a friend or family member to interpret. During her research in similar HIV clinics, Anthonissen (2010) notes that in some cases, negotiating a lingua franca between different L1 speakers might result in one or more participants choosing to communicate in their L3 (Afrikaans) to accommodate service providers.

4.3.1 Counsellors

The VCT counsellors at both clinics are people from the community who were trained initially to provide this particular service and regularly attend refresher courses in the field of HIV counselling and testing. Regarding their language repertoires, at the time of data collection, clinic A employed one counsellor from a multilingual family background who spoke Afrikaans, English and isiXhosa on virtually L1 speaker level, as well as Sesotho on a basic level. She grew up in the town and lives in the informal settlement near the clinic. After starting as a cleaner at the clinic, she applied for the position of counsellor, a position which, at the time of data collection, she had held for 12 years. Between the two counsellors at clinic B, the predominant languages were also covered; the female counsellor, Mary,³⁰ is a native speaker of isiXhosa and speaks English on L2 level and Afrikaans as an L3 while the male counsellor, Charles, is an L1 speaker of Afrikaans with English as L2. While the former had moved to this town from the Eastern Cape, the latter grew up in the area. Since the counsellors fit in the local demographic, all the South African patients visiting the clinic could be counselled and tested in their L1.

³⁰ All names have been changed to protect participants' identities.

Table 4.2 below summarises relevant information on the language biographies of the counsellors: Gretha from clinic A, together with Mary and Charles from clinic B. On a linguistic level it is interesting to note the diversity of L1 among the counsellors. Whereas Gretha and Charles both speak Afrikaans on a native speaker level, Mary speaks Afrikaans as an L3, so that in a predominantly Afrikaans community she conducts most consultations in her least dominant language.

Table 4.2: Counsellors' biographical information

	Pseudonym	Age	Gender	L1	L2	L3	Highest grade completed	Year in which grade completed
A	Gretha	41	Female	isiX, Afr	Eng	Sotho (b)	12	1995
B	Mary	39	Female	isiX	Eng	Afr	12	1998
	Charles	49	Male	Afr	Eng		12	1984

4.3.2 Patients

Although, broadly speaking, many of the linguistic considerations on language distribution and language choice discussed above cover all the counselling sessions recorded, the detail given here will refer only to those that were selected for analysis, i.e. to those conducted in Afrikaans. Tables 4.3 (a&b) and 4.4 (a&b) provide a summary of the relevant linguistic biographical information as well as education and employment information of the patients at each clinic. Columns two and three in table 4.3 give codes: column two gives the codes used in the transcription to identify the particular speaker in the programme; column three codes the type of consultation that was conducted as these categories were found to exhibit type-specific features (to be discussed in more detail in chapter six).

The type-categorisation of the various counselling sessions was done on the basis of the different motivations which brought a patient to the clinic to undergo VCT. On these grounds four patient categories were identified as follows: First, at Clinic A there were mothers who brought their infants for testing as part of the management of the PMTCT protocol. Second, there were pre-/adolescent girls, primary or high school scholars, accompanied by their mothers as part of early assessment and preventive care. In one case the test was part of the standard procedure in the insertion of the state-subsidised birth-control implant, the

IMPLANON®. Third, at Clinic B, patients were tested for general medical reasons and were referred to the clinic since it shares the premises with the state hospital. These cases included testing as part of standard examinations in which a doctor refers a patient. Such procedures include testing to establish a rape victim's status (as soon as possible) during the HIV infection window period. Fourth, there were patients who presented as medical male circumcision candidates. Once a month Clinic B provides voluntary medical male circumcision free of charge and these patients are required to undergo VCT before the procedure. In table 4.3 a and b below column three indicates the particular category to which each patient belongs, where *M-I* indicates mother-infant counselling, *AA* represents accompanied adolescents and indicates mother-pre-/adolescent girl counselling, *Referred* indicates hospital references and general patient counselling and *MMC* indicates medical male circumcision counselling.

Column four in tables 4.3 a and b gives the ages of the participants who underwent counselling. The ages of babies who were being tested are therefore not taken into account, but rather that of the mothers, whereas the ages of the scholars undergoing the HIV test are documented, and not that of their mothers. As can be seen overleaf, with a lowest age of 9 and highest at 50 among the patients at Clinic A, the average age is 28.8 years. At Clinic B with a lowest age of 23 and highest at 67 the average age is 40.7 years. Regarding gender, as recorded in column five, it is interesting that all the patients observed at clinic A were females, while at clinic B in the selected Afrikaans sample 3 were female and 5 were male; in the full sample, 66% were female and 34% were male.

Columns six to eight in table 4.3 a and b give the linguistic repertoires of the participants, showing which languages they know, not only as L1s but also as L2 or L3. As stated earlier, one patient in clinic B chose to accommodate the counsellor by undertaking the session in his L2. The rest of the patients were all Afrikaans L1 speakers of whom eight indicated they had basic (b) to fair English L2 proficiency. That six indicated Afrikaans only and no English proficiency, is surprising as the South African context is a very strong L2 English one and most would claim at least receptive ability in this lingua franca. However, it is likely that in an Afrikaans dominant community, with limited formal schooling and no access to television, participants were truthful in reporting no confidence in their English language capacity.

Table 4.3a: Clinic A: Patients' language biographical information

Pseudonym	Code	Category	Age	Gender	L1	L2	L3
Alison	AMI1	MI	36	Female	Afr	Eng	isiX
Louise	AMI2	MI	36	Female	Afr		
Chané	AMI3	MI	25	Female	Afr	Eng	
Mandy	AMI4	MI	50	Female	Afr	Eng (b)	
Nina	AAA1	AA	17	Female	Afr		
Minnie	AAA2	AA	9	Female	Afr	Eng	

Table 4.3b: Clinic B: Patients' language biographical information

Pseudonym	Code	Category	Age	Gender	L1	L2
Hans	BMMC1	MMC	44	Male	Afr	Eng
Pieter	BMMC2	MMC	23	Male	Afr	Eng
Henk	BMMC3	MMC	43	Male	Afr	Eng (b)
Jo-Anne	BRF1	Referred	23	Female	Afr	
Maggie	BRF2	Referred	45	Female	Afr	
Letitia	BRF3	Referred	47	Female	Afr	
Pedro	BRM1	Referred	67	Male	Afr	
Leon	BRM2	Referred	34	Male	isiX	Afr

Tables 4.4 a and b give an indication of participants' level of formal education and their employment status. The average school grade patients in clinic A had passed (excluding those still at school) is grade 8 (the first year of high school), with the lowest grade passed being grade 6 and the highest grade passed being grade 11. The average school grade passed by patients in clinic B is grade 6, with the lowest having had no schooling whatsoever, and the highest being grade 10. None of the patients had obtained additional, post-schooling qualifications. With the exception of two who were unemployed and one employed in childcare, all patients were employed within the local agricultural industry which includes a truck driver, spray operator and factory worker.

Table 4.4a: Clinic A: Patient education and employment information

Pseudonym	Highest grade achieved in school	Year in which grade was achieved	Additional education	Employment
Alison	6	1995	None	Farm worker
Louise	10	1996	None	Farm worker
Chané	11	2006	None	None
Mandy	6	1970's	None	Childcare
Nina	8-	2014-	N/A	N/A
Minnie	3-	2014-	N/A	N/A

Table 4.4b: Clinic B: Patient education and employment information

Pseudonym	Highest grade achieved in school	Year in which grade was achieved	Additional education	Employment
Hans	7	1984	None	Truck driver
Pieter	10	2009	None	Factory worker
Henk	7	1985	None	Spray operator
Jo-Anne	8	2007	None	None
Maggie	7	1982	None	Farm worker
Letitia	1	1973	None	Farm worker
Pedro	None	N/A	None	Farm worker
Leon	8	1990	None	Farm worker

4.4 ETHICAL CONSIDERATIONS

This study required an extensive process of gaining permission to do the data collection in consideration of proper ethical research procedures. As the data collection was done at two ART clinics with VCT counsellors and patients who visit the clinics, particular care was necessary to protect the dignity and identity of participants. As hearer signals are often not verbal, sound recordings alone would not be adequate, so potentially invasive video recording was necessary. Also, procedures had to be put in place to ensure that no one was put under undue pressure to participate.

Permission to do this research was obtained first from the Research Ethics Committee at Stellenbosch University (Proposal no. HS958/2013; see Appendix A), as well as from the WCDoH (Reference no. WC_2016RP15_290 (2014RP063); see Appendix B). Besides permission from the WCDoH, separate permissions from the managers of the two health care facilities (Clinic A and Clinic B) were required, therefore written permission was also obtained from the most senior managers: the Superintendent of Clinic A and the Clinical Operations Officer of the hospital under whose management Clinic B resides (see Appendices C and D).

All participants, i.e. counsellors, patients and patient advocates (in this case mothers of pre-/adolescent girls) who agreed to be recorded during consultations were properly informed of the nature of the study and the way in which recordings would be handled, after which they were requested to give written consent (see Appendix E(a) and E(b)). Quite a number of patients who were approached actually declined and were not willing to be audio or video recorded. This was of course honoured; in fact, such refusals gave the researcher the assurance that patients who agreed to participate did so voluntarily and were not prompted to do so under pressure of peers, counsellors or the researcher.

4.5 DATA GATHERING

As indicated in 4.3 above, before the data gathering commenced, ethical clearance from both the Research Ethics Committee: Human Research (Humanities) of the University of Stellenbosch as well as the WCDoH was obtained. Through email correspondence and telephone conversations, the researcher communicated with the relevant officers at the two clinics and after gaining their permissions, established the ideal dates for appointments to do the data collection at times that would not be disruptive to the regular working programmes of the clinics.

4.5.1 Informed Consent

Informed consent to record counselling sessions was obtained in formal printed and signed format for all participants (counsellors and patients). Care was taken to ensure they clearly understood what the research wanted to achieve, and how recordings would be made and then managed afterwards. In explaining the study participants were assured of confidentiality in that their identities and other potentially sensitive information would remain undisclosed.

Pseudonyms would be used to assure anonymity, and the video recordings would be viewed and used by the researcher and her supervisors only. Participants could at any time during or after the recordings withdraw their participation or request that any material or information they had provided be destroyed. Further, participants were given the opportunity to ask questions throughout. For Afrikaans L1 and proficient English L2 participants, information was given by the researcher; for isiXhosa or Sesotho L1 speakers with low English proficiency, the counsellors at both clinics acted as interpreters.

Together with the obtaining of informed consent, a questionnaire was distributed on which participants were requested to provide the necessary metadata (see Appendix F). These forms collected information on participants' name, age, gender, place of birth, place of schooling, current home town, highest school grade completed, last year of formal schooling, mobility in terms of how they travelled to the clinic, language repertoire, additional qualifications as well as current and previous employment. The questionnaires were completed by either the researcher or the counsellor in consultation with the participants. This information has been summarised in table format (tables 4.3 a and b and 4.4 a and b) with participants already anonymised in section 4.3 above.

4.5.2 Media

As the choice to collect video recorded data was contentious in that concerns were raised by the Stellenbosch ethics committee regarding the invasive nature of the technology and the threat to participant anonymity, this section will motivate this procedure by referring to literature on such multimedia in research. Cahill and Papageorgiou (2007:909) suggest that any data collected in an audio format without the visual element in medical consultations would be insufficient for providing accurate observations about the consultation. They argue that the use of silence and performance of nonverbal interactional elements has an effect in consultation (2007:909). In accordance, Kendon (2007:20) elaborates on the advantages of video recording as it permits a researcher to investigate elements of roleplaying and how they are integrated in the unfolding of face-to-face interaction. Such elements include “[t]ones of voices, modes of hesitation, styles of talking, patterns of intonation, vocal quality, bodily posture, bodily movements ... glances, [and] facial expression” (Kendon, 2007:20). In their study on the online counselling of young people, Bambling, King, Reid and Wegner (2008) found that the absence of nonverbal cues in patients' written messages caused difficulty in the assessment of the extent and intensity of issues they had raised. In further support, Gillis

(1992:60) argues that various messages are conveyed through body language, whether it be postural, gestural, expressional or even through the way an individual is dressed. She suggests that “[a]ny realistic understanding of the client’s feelings must therefore be based not only on attentive listening, but also on active observing” (Gillis, 1992:61).

Although many researchers emphasise the importance of audiovisual recordings in face-to-face interaction, Jones and LeBaron (2002:516) advise that one should not see visual recordings as a complete representation of activities. They point out that limitations exist in the form of “camera angles, camera scope, the absence of other sensory input” among others. In their study on the presence of a video camera in patient-physician interaction, Arborelius and Timpka (1990) focus on the influence this device can have on participants. They believe that while the influence is mostly on the psyche, the presence of a video recorder does not necessarily affect the behaviour of speakers. They found that where there seems to be an influence, it is minimal and mostly at the beginning of the consultation only.

Data were therefore collected using two types of research instruments, namely video and audio recordings. The data consists of pre-test VCT counselling sessions of which the recording runs from the moment the participant enters the counselling room until before the participant signs the medical consent form required before blood is drawn for testing. Both the video camera and dictaphone were operated solely by the researcher who was not present during the sessions but controlled the devices before and after a session was conducted. The video camera was focused on the patient alone, therefore the counsellors as well as their linguistic behaviour is not always in view. In cases where the counsellor moves or stands up, some of their physical behaviour and movement can be seen. The reason for this perspective that captured the patient only is two-fold: firstly, the study focuses solely on the responses of patients as listeners during the counselling sessions. Secondly, the venues in which the video recordings were made did not provide enough space to accommodate two video cameras. The spaces provided by these rural clinics are very small so that positioning one video camera appropriately already proved to be challenging.

4.6 TRANSCRIPTION

Once recordings had been completed they were transcribed so that they became available in a format which facilitates analysis. “The transcript plays a central role in research on spoken discourse, distilling and freezing in time the complex events and aspects of interaction in

categories of interest to the researcher” (Edwards, 1993:3). Capturing spoken language which is otherwise fluid and effervescent renders it static in a manner that is beneficial as it offers a researcher numerous opportunities for reviewing and investigating a phenomenon that is essentially continuous as it unfolds in real time (Jenks, 2011:7). Jenks (2011:12) distinguishes between an open and closed transcript. In creating an open transcript, the researcher includes all detectable elements, approaching the data holistically in order to document every possible linguistic and communicative feature. A closed transcript is created when a researcher approaches the existing data with her/his research questions and interests in mind, including only the relevant linguistic features observed. The transcripts of this study fall somewhere on the continuum between these poles. So, for example, in this study gestures that did not contribute structurally to the development of the interaction were not transcribed, although linguistic features irrelevant to the exploratory aims of this study such as phonetic forms were included by orthographic means. This was done with the potential value of the data for future research where such thorough documentation would allow for a new round of working with the raw data.

The audio material was transcribed using transcription software developed at the University of Hamburg as freeware available as EXMARaLDA (**Extensible Markup Language for Discourse Annotation**). Transcription was done by the researcher as well as trained research assistants. In order to maintain confidentiality, the meta information and speaker tables of each transcription were documented by the researcher alone. The meta information includes the project name, referenced audio file, place, time, date, as well as additional comments such as the reason for the patient’s visit (e.g., medical male circumcision or the verification of PMTCT). The participant meta data (or speaker table) then includes the following information of both the counsellor and patient: full names, language used during consultation, L1, L2, etc., age, gender, birthplace, place of schooling, current hometown, grade completed, year in which that grade was completed, additional qualification, and employment.

In the transcription, each participant was assigned her/his own set of tiers in which different kinds of information are represented. Each conversation consists of at least two participants: counsellor (C), patient (P) and in the case of the accompanied pre-/adolescents, the patient’s mother (PM). The counsellors were given four tiers, while the patients were allocated an extra tier in which the nonverbal features were transcribed. Additionally, the number of each interval (in the sequential order of produced utterances) together with the time at which it was

spoken are given in the grey highlighted top row (e.g., 41 [01:02 1]). Each tier as well as the information that it represents are listed as follows:

Tier 1 [v]: captures the basic written transcription of verbal utterances alone.

Tier 2 [FP]: provides the formal pronunciation of that transcribed in the [v] tier in cases of informally articulated utterances. Here, standard orthography is used throughout in that capital letters, commas, full stops and so forth are used as they are in written language.

Tier 3 [ENG]: contains the English translation by the researcher of that said in the previous tiers. This caused for some difficulty, especially given the syntactical difference between Afrikaans (an S-O-V language) and English (being S-V-O).

Tier 4 [SUP]: contains annotative suprasegmental information about the way in which words were articulated. This tier mostly provides information regarding the intonation of utterances, or whether the speech was loud, soft, etc. When words (or abbreviations such as HIV) were produced in English, this was also indicated in the [SUP] tier (as *HIV: EP*).

Tier 5 [NV]: provides a transcription of nonverbal behaviour of only the patients. This tier only provides a transcription of nonverbal behaviour that contributes as hearer signals such as nods and head shakes.

Tier 6 [K]: an additional tier which is not linked to a participant, contains any additional comments of the transcriber. This tier was mostly used to comment on meta-information during the transcription process for instance in cases of uncertainty of articulation.

Since both participants are not necessarily speaking or gesturing at the same time, not each extract from the transcription will contain all four or five tiers of the counsellor and patient(s) respectively. In the same way, if one participant is passive throughout an extract from the transcribed piece of text, the tiers – which contain no information – will be omitted from the extract. With this in mind, refer to the extract overleaf for an example of the description of tiers provided above.

	41 [01:02.1]	42 [01:04.7]	43 [01:05.1]	44 [01:06.0]
C [v]	• • soos dit, • • soos jy daai sien op 'ie prentjies, • •	dis seksuele oor-	dra'bare	
C [FP]	<i>soos dit, soos jy daai sien op die prentjie,</i>		<i>draagbare</i>	
C [ENG]	• • like that, • • like you see there on the pictures,	• •	that's sexually trans-	mitted
C [SUP]	rising intonation at end			
PM [v]				Hm̃
PM [SUP]				affirmative
PM [NV]		<i>nodding</i>		

After the initial and basic written transcription of verbal utterances alone, the researcher verified the accuracy a first time by ensuring basic grammatical correctness before translating the Afrikaans into English. After creating a basic or foundation transcript, attention was turned to the research questions and aims. Jenks (2011:13) mentions the importance of “understanding the empirical objective” which will shape the transcription process. The next round of transcription work was thus to accurately represent intonation and pauses. A third inspection, focusing only on the audio was then done. Up until this point the only reference that was made to the visual was to solve ambiguities in articulation found by transcribers. Although Jenks (2011:73-74) advises the researcher to be aware of the omnipresence of nonverbal behaviour in communication, the researcher chose to describe all the relevant acts systematically, focusing on one linguistic element at a time in order to avoid straying off topic through distractions.

After this verbal transcription, the visual material was transcribed alongside the already existing transcription within its own, nonverbal (NV) tier to complement the verbal part. In order for the end product to facilitate the desired analytic observations, again, it was essential to consider and understand what kinds of nonverbal behaviour actually contributed to the conversation. With the investigatory aims in mind, decisions were taken about which of those movements were to be included in the transcription (Jenks, 2011:74). Because not all aspects of behaviour could be transcribed, in this case the researcher focused mostly on head nods and other nonverbal behaviour that could be classified as hearer signals throughout the listening process.

4.7 TRANSCRIPT NOTATION

A recurring feature of dialogue that is important in this study is the simultaneous production of utterances by participants, i.e. the overlapping of utterances. This feature has proven difficult to transcribe accurately in the past. The EXMARaLDA transcription program,

however, provides an ordered sequence of time points; each interval or unit with a beginning and end time, in which all verbal and nonverbal events within that time frame are transcribed. It has been transcribed in such a way that whenever a participant interrupts another or an overlap occurs in the speech, a new interval is created. With the transcription of the sequence of events taken care of, there are still, however, specific interactional phenomena that need to be noted in the transcription. Below follows the full list of the transcription signs used in this study.

•	Pause between 0 - 0.25 seconds
••	Pause between 0.25 - 0.50 seconds
•••	Pause between 0.50 - 1 second
((2,3s))	Pause longer than 1 second are indicated in double brackets
((coughs))	Double brackets are also used for vocal phenomena that may be difficult to transcribe
...	Ellipses dots are used to indicate aborted and unfinished utterances
/	Forward slash is used to indicate a repair in a sentence
—	Emphasised words or phrases are underlined
.	High points are used mostly in listener feedback and indicated that the hearer has no intention of taking the floor with her/his utterance
—	Indicates smooth or rapid transitions between touching/bordering utterances. In these cases, the natural pause between sentences is left out
Jaa/Yees	Elongated words are indicated by adding an extra letter of that which is extended
H ^h m	Intonation: rising falling tone
H ^h n	Intonation: rising tone
H ^h m	Intonation: falling tone
H ^h m	Intonation: falling rising tone

Hm̃

Intonation: level tone

4.8 ANALYSIS

Orum, Feagin and Sjoberg (1991:12) mention a type of precision that a qualitative research design assures in analysis, namely that it “record[s] ... social life as a meaningful whole, not as the sum of lifeless quantitative units.” By taking a qualitative approach, the researcher aspires to explore and describe the complex and subtle conversational nuances within the specific social context of pre-test VCT counselling sessions, “permit[ting] as much flexibility into the judgments made about the world as possible” (Orum et al., 1991:23).

The objectives of this study are to (i) identify the generic features of counsellor-patient communication in formal pre-test VCT counselling sessions as a conversation, (ii) identify the forms of hearer signs and signals that occur in pre-test HIV consultation communication, (iii) interpret these signals, (iii) select the most widely used forms for specific analysis regarding their function and interactional contribution. In order to achieve these aims, data will be analysed over two chapters in the form of an investigation guided by the theoretical framework of CA (chapter five) and a presentation and interpretation of an inventory of hearer signals found (chapter six).

4.8.1 CA investigation

From a Linguistic Pragmatics approach, chapter five will apply the theoretical framework of CA with the goal of characterising the structural features found in pre-test VCT counselling sessions as a conversation type. Here recurring patterns within this specific discourse will be identified in order to explain a variety of its interactional features. The approach to this endeavour will not be based on preconceptions of the data, but will aim to reflect unmotivated looking which Schegloff (1996:172 cited in Ten Have, 1999:103) defines as an investigation aimed at noticing ordinary interactional features, rather than one driven by preformulated analytic aims.

In order to achieve this, a specific methodology based on various analytic strategies will be followed. On a basic level, the process will follow Pomerantz and Fehr’s (1997:71-74, cited in Ten Have, 1999:105-107) guidelines for developing conversational analyses. These

guidelines are based on what they identify as fundamental areas to consider while doing CA and are listed as follows:

- (i) “Select a sequence.” They (Pomerantz & Fehr, 1997:71) suggest that one should determine the commencement (i.e. turn in which an action/topic is initiated) and end (instance when participants’ speech acts do not refer or respond to that action/topic) of the sequence. The sequences used for analysis in this study include the opening and closing sequences of the session, question-answer adjacency pairs and typical monologue-style information-giving statements during which the patient as recipient provide passive responses or hearer signals with various functions.
- (ii) “Characteri[s]e the actions in the sequence.” The main aim here is to describe the function behind a participant’s turn. When this is done for each turn in succession, the relationship between sequential actions can be interpreted.
- (iii) “Consider how the speakers’ packaging of actions, including their selection of reference terms, provides for certain understanding of the actions performed and the matters talked about. Consider the options for the recipient that are set up by that packaging.” Pomerantz and Fehr (1997:72-73) suggest that one should take the form in which the action is accomplished into account regarding potential alternatives. Here it is important to ask why an utterance is produced the way it is, and what options of response it might hold for the recipient.
- (iv) “Consider how the timing and taking of turns provide for certain understandings of the actions and the matters talked about.” As the most basic feature of conversation, turn-taking cannot be ignored. During this step, turn initiation, termination and selection should be analysed (Pomerantz & Fehr, 1997:73).
- (v) “Consider how the ways the actions [are] accomplished implicate certain identities, roles and/or relationships for the interactants.” The ways in which actions refer to the “rights, obligations, and expectations” of different participants, must lastly be considered (Ten Have, 1999:106).

In addition to these guidelines, four organisations of conversational sequences as set out in Ten Have’s (1999:107) analytic strategy will receive attention. This includes making general observations regarding the organisation of turn-taking, sequence forming, repairs and turn constructional design. In this way, pattern and deviant case analysis will be used to explore

the relation between turn design and consequent conversational sequences in order to reveal patterns that will aid in the understanding of HCP-patient interaction (Drew et al., 2001:62). To reiterate, the four central sequence types that are uniformly found in pre-test VCT counselling sessions will be studied: openings, closings, question-answer sequences and generic sequences in the form of long, monologue-style rhetorically rigid counsellor information-giving statements.

4.8.2 Analysis of hearer signals

By using Corpus Linguistics, chapter six will follow up on the previous section in order (i) to identify the forms of hearer signs and signals that occur in pre-test VCT counselling sessions, (ii) to interpret these hearer signals, and (iii) to select the most widely used forms in order to analyse their use in signalling various messages of the patient, and their contribution to the conversation.

Hearer signals will be divided into verbal and nonverbal speech acts. While nonverbal hearer signals include nods and head shakes as feedback, verbal hearer signals are further divided into (i) non-speech utterances (such as “hm”), (ii) one-word utterances (“okay”), as well as verbal signals that take the form of (iii) phrases used as continuers (“I understand”) as well as content-specific phrases that provide feedback specific to the speech at that time.

In setting up this corpus, specific attention will be given to distinguishing between responses like “yes” and “hm” that exist as a second part in an adjacency pair, and the same utterances produced as hearer signals with different functions. Cf. section 3.5.2 for a detailed definition of hearer signals as interpreted in this study. After the hearer signals found in the data is categorised in terms of its linguistic form, the focus will shift to their function within this context. Methods that will be used in establishing signals’ underlying functions will include –

- (i) analysing each signal in relation to preceding and following speech of the speaker as hearer signals often comment on the content of ongoing speech, are produced structurally throughout the speech, or speakers can be found to prompt the production of hearer signals,
- ii) taking into account the overall success of the conversation as a whole, e.g. by referring to following speech from the patient which can reveal understanding,
- iii) considering pragmatic and contextual factors in which the meaning of these speech acts can be determined, and

- iv) examining the patient as hearer's behaviour in terms of body language, facial expression and overall participation.

In this way, chapter six will provide a corpus of hearer signals in terms of their form, after which the most prevalent forms will be highlighted. The different functions underlying the production of these hearer signals in pre-test VCT counselling sessions will then be listed, before providing the top hearer signal functions underlying each signal type.

4.9 CONCLUSION

This chapter provided a description of the methods that were applied in collecting, transcribing and analysing the data for this study. The following two chapters apply these methods in two analyses. In establishing pre-test VCT counselling sessions as a conversation type in the medical discourse genre, chapter five analyses the underlying order and structure found in these conversations within the framework of CA in order to identify its generic features. Chapter six then follows on the first analysis by examining the form and functions of a prevalent linguistic phenomenon found in these conversations, namely hearer signals.

Chapter Five

CONVERSATION ANALYSIS

5.1 INTRODUCTION

In order to investigate health care discourses, it is important to establish medical interviews as a distinctive discourse in its own right. Consultations between HCPs and patients have received much scholarly attention because those working in the area believe such investigation to be necessary in order to better understand the collaboration between HCP and patient (Mishler, 1984:7-8). Although much research has been done on communication within the clinical practice (cf. section 3.4), the majority thereof is on doctor-patient communication within diagnostic consultations. This study is concerned with a subtype of the larger discourse of medical consultations which has not been characterised in discourse studies before. Within medical interviews as a discourse genre, quite a number of subtypes of conversation, each with its own characterising features, can be established. Such subtypes include HCP-patient communication such as pharmacist or psychologist-patient communication as well as communication between HCPs which includes consulting physicians with each other as well as physician-nurse communication. Counsellor-patient communication then also falls within these subtypes.

On a general level one can identify doctor-patient communication (cf. Byrne & Long, 1976; Pendleton, 1983; Pendleton & Hasler, 1983; Stewart, 1984; Rehbein, Heath, 1984; 1986; Wynn, 1995; Peräkylä, 1997; Bührig & Meyer, 2004; Heritage & Maynard, 2006; Gerber, 2013) as a kind of conversation on which research reports have commented regarding communicational structure, the balance of power, doctor- vs patient-centredness, diagnosing, different types of conversational sequences, body language, etc. The nurse, who is positioned lower than the doctor in the HCP hierarchy, has a different role within medical practice, a different relationship with patients and therefore also engages in different kinds of conversations with patients (cf. Caress, 2003; Jones, 2003; McCabe, 2004 & Candlin, 2006; Barrere, 2007 & Berry, 2009). Within the context of medical practice, the VCT counsellor, who typically has no medical training, can then be categorised as lower than either the doctor or the nurse in the HCP hierarchy.

Although there are many other HCP profiles (clerical staff, pharmacists, surgeons, assistants, etc.), each with their unique role and accompanying conversation with patients, this study attends only to the three roles that are most salient in HIV state care. Below, in figure 5.1 a visual representation is given of the basic and most applicable hierarchy in management and decision-making among doctors, nurses and VCT counsellors in this context. These three roles are represented, together with possible types of conversation that exist within their communication with patients. This figure shows how various genres in medical discourse are situated within the context this study refers to.

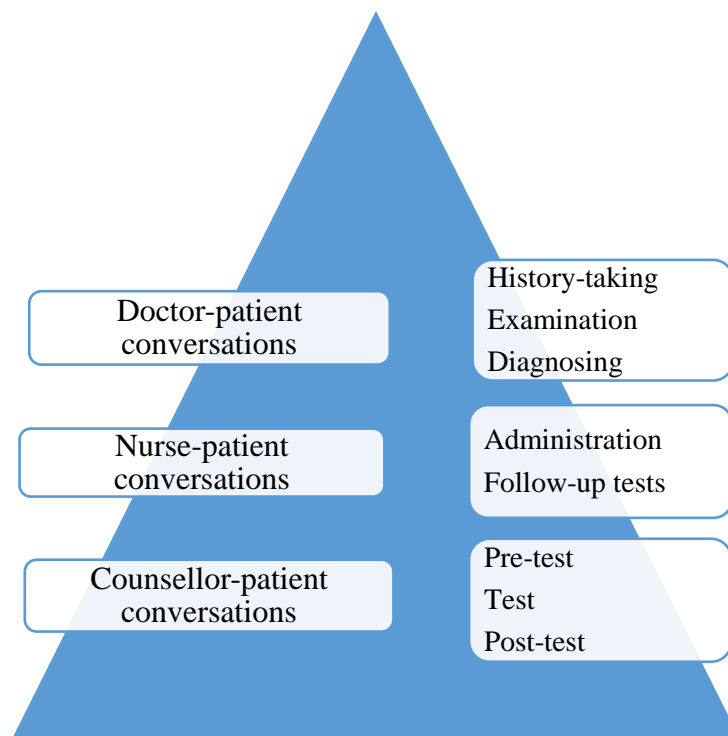


Figure 5.1: Types of conversation found in medical discourse

Where doctor-patient communication includes different conversation types such as the diagnosing process with its own generic features, nurse-patient conversation types can also vary depending on whether they are intended to build a relationship or accomplish nurses' administrative tasks. Three types of conversations are found between VCT counsellors and patients: pre-test counselling, conversation during the test, as well as post-test counselling. Each of these conversations is known to have distinct characteristics, topics and conversational sequences. The type of conversation that is important to this study, is the pre-test VCT counselling session. Although studies have focused on HIV counselling in general and different aspects thereof (cf. Harris, 1988; Green, 1989; Peräkylä & Bor, 1990; Peräkylä,

1995; Sherr, 1999; Kinnell, 2002; Iafigliola-Kriner, 2006; Anthonissen & Meyer, 2008; Rosenberg et al., 2013), this specific type of conversation has not been characterised before in terms of distinguishing features of form and function. This chapter aims to determine the features of pre-test VCT counselling sessions on the basis of the cases observed.

Within this conversation type, further subtypes are found in which there are varying types of patients (as hearers). The two clinics from which data were collected delivered distinct types of participants. As has been illustrated in more detail in chapter four (4.3.2), the data were divided into four conversation categories depending on the reason for the patient's visit. Clinic A delivered (i) mothers testing their infants (AMIs), in which case the mother or guardian, despite not being tested herself, takes the role as hearer. Clinic A then also provided (ii) pre-/adolescent females (AAAs) accompanied by their mothers in which there exists a triadic conversation as both the patient and her mother participate as hearers in the conversation. Data from clinic B provided (iii) male patients undergoing VCT as part of the voluntary MMC service protocol (BMMCs), as well (iv) female and male patients referred to VCT by other HCPs for various reasons (BRFs & BRMs) (cf. section 4.3.2).

5.2 CONVERSATION ANALYSIS

Because VCT is conversationally enacted, the framework given by CA has been chosen for identifying the generic features of this kind of medical consultation. The aims of CA (as set out in section 3.2 of chapter 3) are to analyse the frequency of specific sequential phenomena that occur throughout conversation in order to provide a formal description of its underlying order and structure. The development of Institutional CA (cf. section 3.3.5) is specifically relevant to health care communication, as interaction within medical consultation, and especially HIV counselling as a medical conversation is guided by the VCT protocol. Counsellors control the conversation as they orient its development towards covering a fixed list of conversational topics in accordance with a protocol set out and taught to them during their training (cf. section 2.4).

In this way, as Drew and Heritage (1992:21-25) suggest, the features of pre-test VCT counselling as a conversation of institutional interaction are shaped into specific structures and procedures orientated towards achieving the goals of the institution. The counsellor's goals within this conversation type are (i) transferring specific information to the patient (cf. section 2.4.3.1) and (ii) ensuring that the patient understands that information. This

information-giving nature of the pre-test VCT counselling session from the start clearly produces a monologic instructing style, in that the counsellor controls the conversation according to the protocol's checklist of topics that have to be covered. This imbalance of conversational turns ensures the occurrence of several hearer signals from the side of the patient. Hearer signals thus become a significant feature of this conversation type.

The three interrelated levels of the analysis of medical conversation include (i) individually designed turns of talk that together form (ii) sequence structures representative of interactional activities or tasks which in turn, are assembled to form (iii) the structure of the consultation as a whole (Heritage & Maynard, 2006:13). CA was developed in the process of identifying the behavioural patterns formed by such sequentially connected events in order to develop theories regarding the uses and structured properties of the conversational practices of the discourse at hand (Heritage, 1995:399). In determining these patterns, it is important to recognise and include 'marginal' and 'deviant' cases. While marginal (i.e. less regular) cases assist in defining conversational features, analysing participant behaviour in the deviant (i.e. a-typical) cases can provide insight into the level of normativity of the conversational practices (Heritage 1984:241-260, cited in Heritage, 1995:399) in that it contributes to the authentication of empirical findings (Heritage & Maynard, 2006:13).

Based on the cases observed in this study, the generic structure of pre-test conversation in VCT as a whole is uniform throughout all the counselling sessions. After the opening sequence follows a question-answer sequence in which the counsellor (sometimes) makes small talk, asks situational questions about the patient (which are usually subtype specific) and then inquires as to the patient's knowledge of HIV and related issues suited to the conversation subtype (e.g., questions to mothers testing their infants may refer to the baby's eating habits). The bulk of the counselling session then takes the form of an information-giving sequence during which HIV/AIDS related content is covered by the counsellor as speaker. After this educational phase follows a questionnaire-type question-answer sequence during which the counsellor fills in the consent form by asking the patients various health-related questions. This is followed by the closing sequence in which the pre-test VCT counselling session (viewed here as conversation) is brought to a close. The sequences observed and investigated and that will be described in this chapter are thus openings, closings, question-answer sequences and the generic monologue-style rhetorically rigid counsellor information-giving sequences in which hearers take a passive role and give

feedback on the back channel. The general structure of pre-test VCT counselling sessions take the form of an organised sequential combination of these sequences and is schematically presented in figure 5.2 below.

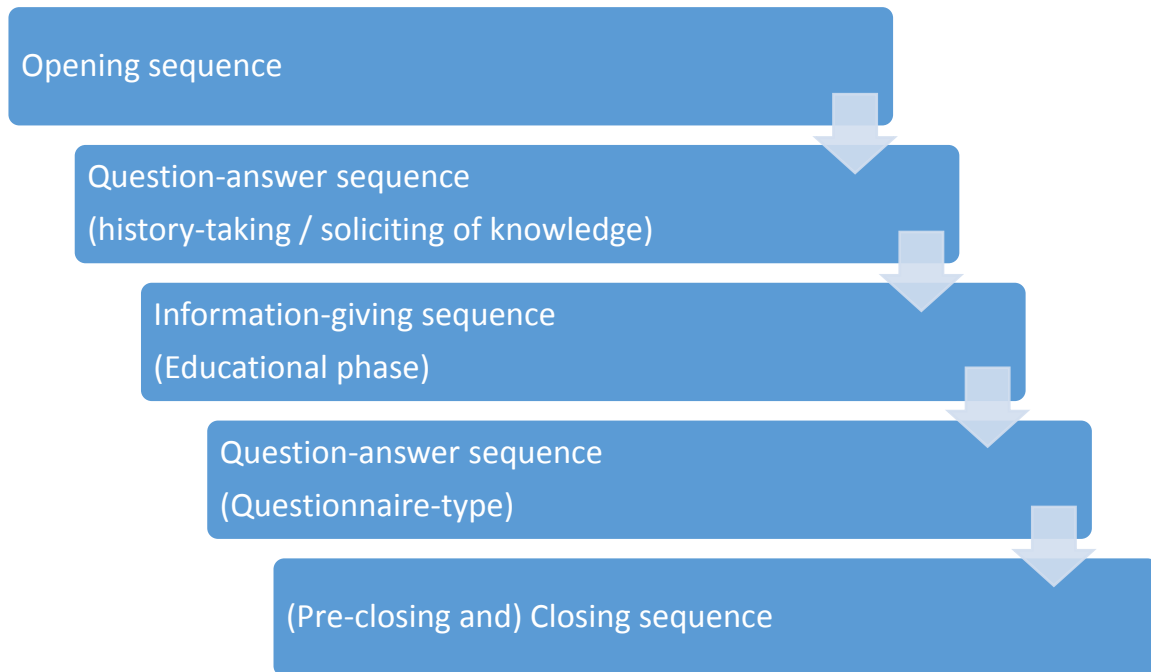


Figure 5.2: Schematic representation of successive sequences in pre-test VCT counselling sessions

For each sequence type, generic features within pre-test VCT counselling as a conversation will be listed, while also giving attention to cases where the structure deviates from the regular pattern.

5.3 OPENING SEQUENCES

Opening sequences are judged to commence with the first conversational act carried out by an interlocutor once two (or more) participants gather in an encounter. It is then also deemed finished as soon as information-giving or question-answer sequences regarding the order of business are initiated. This might be in the form of the counsellor informing the patient of the process that is to follow or the counsellor asking the patient about her/his knowledge of HIV/AIDS and indicates the start of the next sequence as information-giving or question-answer respectively. Excerpt a) overleaf can be regarded as an introductory example.

a) *Chané (AMI3) and Gretha*

	1 [00:00.6]	2 [00:01.3]	3 [00:02.3]	4 [00:03.0]	5 [00:05.2]
C[v]	Daa's'y Mammie.		Gan 'it me' jou?		Ek is Gretha ••• E' gan
C[FP]	<i>Daar's hy Mammie.</i>		<i>Hoe gaan dit met jou?</i>		<i>Ek is Gretha. Ek gaan</i>
C[ENG]	There you go Mom-my		How are you?		I am Gretha ••• I will
C[SUP]					rising intonation at end
P[v]		•• Hm̃		•• Dit gaan nog goed • kan nie kla nie.	
P[ENG]				I'm still well, can't complain.	
P[SUP]		softly		rising intonation at end	
	..		6 [00:08.6]		7 [00:13.0]
C[v]	jou berader vir die dag wees.		((2,2s)) En wie is die een wat kom van julle twee?		
C[FP]	<i>jou berader vir die dag wees.</i>				
C[ENG]	be your counsellor for the day.		((2,2s)) And which of you two are coming here?		
C[SUP]			excitedly, as if speaking to a child		
P[v]					•• Ek is Chané
P[FP]					<i>Ek is Chané</i>
P[ENG]					•• I am Chané
P[SUP]					rising intonation

5.3.1 Generic features

The first generic feature that is apparent across each subtype is that each conversation is initiated by the counsellor. Patients are observed to do different things while counsellors settle their administrative business: mothers with babies tend to their children, pre-/adolescents look around the room to avoid eye contact, etc. There are also two incidences in which a patient makes eye contact and produces a nod as a display of reciprocity (Heath, 1986, cf. section 6.3.6.2). In the majority of cases, it is clear that patients keep their attention on the counsellor in anticipation of the counsellor starting the conversation.

This behaviour could correspond with Schegloff's (1968) distribution rule (cf. section 3.3.4.3) in which he suggests that the ringing of the telephone forms the first pair part of an SA sequence. The patient's visit, or her/his presence in the counsellor's office, like the ringing of a telephone, could act as the first pair part of a SA sequence, to which the counsellor then must provide a second pair part. Alternatively, and more likely in this context, this behaviour could be an indication of patients taking their institutional role in a fairly unknown context opposite the counsellor as the professional who will be leading the conversation. As a stranger to the situation, first time patients enter a context with protocols unfamiliar to them and do thus not know how to respond, leaving their co-participant (familiar with the process) to direct and lead a semi-scripted conversation which they must follow. In this way, it can be

assumed that patients yield in silence as to be led by the goal-oriented structure of institutional talk.

The initial utterance then provided by the counsellor across the sessions is observed to take the form of two types of first pair parts, namely greetings and summons. Counsellors often greet patients by saying “good morning” or “hello”, to which most patients respond accordingly. The single exception to this occurs during a counselling session with an accompanied pre-adolescent girl. After the girl fails to respond to the counsellor’s produced first pair part of the greeting, the mother as (unaddressed) side-participant addresses the fact that the expected second pair part is absent by telling her daughter to “say hello.”

The SA sequences, of which interval 1 in excerpt a) above is an example, occur verbally in the form of the counsellor addressing the patient in some way or another including uttering the patient’s name (“Minnie” (AAA2) / “Henk Nel” (BMMC3)), or referring to their social role (“Okay, girl” (BRF1) / “There you go, Mommy” (AMI3)). Although a response in the form of a soft “Hm” is provided by the hearer in interval 2 of excerpt a), this summons does not often receive a possible preferred response (cf. section 3.3.4.2) and in some cases the counsellor does not provide a pause in which a response can be produced. In this way it could be produced to act more as an attention-getting mechanism in announcing the start of the conversation.

Two sessions are initiated with the discourse marker, “okay”. Typical to its function, this utterance is used to connect pieces of discourse (cf., for example, section 3.3.4.4 regarding pre-closings). In the case where there is no discourse preceding the next utterance, it can be used to conclude a preceding action within the discourse, like cases in which counsellors are busy with administrative tasks such as writing on forms before the commencement of the conversation. In this way, it concludes preceding action and announces the beginning of a new conversation or utterance, or could also aim to get the attention of the patient. In both cases, these discourse markers precede a summons.

What follows these initiating sequences throughout typically takes the following forms:

(i) Questions regarding the addressee’s state. After each acknowledgement or summons explained above, the counsellor follows by initiating a responsive cycle (cf. section 3.3.4) in the form of a question such as “How are you?” or “What does the mother say?” (AMI4) which are both ways of inquiring as to the addressee’s state (see interval 3 in excerpt a)

above). Each of these initiated adjacency pairs contains a pause during which the counsellor relinquishes the speaking turn and the roles are reversed as the patient provides a second pair part as seen in interval 4 above.

(ii) Informative/introductory statements. Throughout the data, these introductory statements aim to inform new patients as to (i) the counsellor's name, and (ii) her/his position within the clinic: "I am Gretha, (pause) I will be your counsellor for the day" (interval 5 in excerpt a)). All of these sequences occur after the initiation of conversation and the only sessions in which it does not occur, show clear evidence that it is a follow-up conversation and that the participants have already met each other.

(iii) Statements or questions regarding the reason for the patient's visit (see interval 6 above). In most cases (usually after introducing themselves), the counsellor asks the patient for the reason behind her/his visit. This is interesting bearing in mind the fact that all patients visit counsellors for the same reason. While it is understandable that a doctor might inquire to the reason behind a general patient's visit, it is clear in this instance that the counsellor is in fact knowledgeable as to the intention of a patient's presence (cf. section 3.4.1.1). Since it is such a prominent generic feature found throughout all three counsellors' repertoire, one might assume that this kind of question is encouraged in counsellor training as the answer provided would be a direct reflection of a patient's degree of understanding around the situational context. This kind of patient inclusion is also an example of a patient-centred approach within counselling, or might be produced to promote patient participation in general in order to make them feel more at ease.

5.3.2 Deviant cases

On a structural level, excerpt b) in the examples below provides a deviant case that starts with a question instead of the generally observed summons or greeting as explained above. The argument here is that the counsellor asks the question before joint alignment has been established between the participants, as she is walking away from the patient as the question is uttered. After the counsellor closes the door and takes her seat, however, she returns to the generic opening by starting with a summons before introducing herself. This deviant case might be seen to contain a kind of pre-opening sequence during which the counsellor makes small talk by asking a question before officially starting the conversation later.

There are three cases observed in which the counsellor's informative statement of personal introduction does not occur. In two of these sessions, it soon becomes clear that the patient is not a newcomer, and that this kind of introduction has been covered during a previous conversation. This fact is made clear by the counsellor "we have already spoken" (AAA1) or by the patient who shows that she already knows the counsellor by addressing her on her name. With this being said, there is one session in which an introduction is omitted in which there is no clear indication that this is a follow-up consultation. Since this is a mother testing her baby, however, it might be assumed that it is not her first visit since women are usually tested during pregnancy according to protocol and this case occurs in clinic A which only has one counsellor.

Furthermore, there are three cases observed that deviate from the question-answer sequences regarding the reason for a patient's visit. All of these cases occur with referred patients in clinic B in consultation with the same counsellor. It is interesting to note that in these referred cases the counsellor does not omit the topic of the reason behind patients' presence, she merely changes the responsive cycle in the form of a question-answer sequence to a narrative cycle in the form of an information-giving sequence. This could be due to the fact that these patients are not there by personal choice, but were referred by an HCP and might be uncertain as to the reason behind their visit.

5.3.3 Example

To restate, excerpt a) provides an example of a typical opening sequence found in these conversations. The counsellor initiates the sequence with a summons, which is responded to by Chané (2). This is followed by a question-answer sequence and an introductory statement by the counsellor (5). The turn-pair that terminates the opening sequence takes the form of the counsellor indirectly asking Chané for the reason behind their visit, which is then answered and followed by the next sequence-type during which the counsellor asks history-taking questions.

Excerpt b) overleaf provides a deviant case in which the first turn in the opening sequence is a question.

b) Letitia (BRF3) with Mary

	1 [00:07.3]	2 [00:09.3]	3 [00:09.8]	4 [00:11.1]	5 [00:11.7]	6 [00:12.2]	7 [00:17.3]	
C[v]	Is dit jou ee'ste keer ve'dag hier?		Is 'it/ Is 'it die eerste keer?		Aah.		Okay,	
C[FP]	<i>Is dit jou eerste keer vandag hier?</i>		<i>Is dit/ Is dit die eerste keer?</i>					
C[ENG]	Is today your first time here?		Is it/ Is it the first time?				Okay,	
P[v]		• Hm?		Hñhñ.		((3,s)) ((nod))		
P[SUP]				negative				
P[NV]				<i>shaking head</i>				
[K]						((Door closing))		
	8 [00:17.8]	9 [00:18.]	10 [00:18.6]	11 [00:19.7]	12 [00:21.0]	13 [00:21.1]	14 [00:22.3]	15 [00:23.0]
C[v]	•	kyk hier.		My naam is Mary, nè?		• Ek is 'ie berader.		So, • uuh • • wat gat ons
C[FP]				<i>My naam is Mary, nè?</i>		<i>Ek is die berader.</i>		So, uh, wat gaan ons
C[ENG]	•	look here		My name is Mary, right?		• I am the counsellor.		So, • uuh • • what we're going to do
C[SUP]						rising intonation		
P[v]			• • • Hñhñ				Uñh	
P[SUP]			affirmative					
P[NV]	<i>nod</i>				<i>slight nodding</i>			
	..					16 [00:28.2]	17 [00:29.8]	
C[v]	nou/ wat gat nou gebeur, nè? • • Ons gan mar net vir jou uuh					((2s)) ((unint., 1,4s)) ((1s))		
C[ENG]	now/ what will happen now, right? • • We will just uuh							
P[v]						Kan e' mar nader sit?		
P[FP]						<i>Kan ek maar nader sit?</i>		
P[ENG]						May I sit closer?		

It is firstly important to describe the physical behaviour of the patients as captured by the visual recording as an important part of the opening. Utterances from interval 1 to 5 occur as the counsellor is busy with administrative tasks. The reason why the patient initiates a repair in interval 2 could be due to the fact that there is no joint alignment between the participants since the counsellor asks the first question (1) as she is walking around the consultation room and is not facing Letitia as she poses the question. This obscured way in which the question was asked can be seen as a violation of Grice's maxim of manner (cf. section 3.2.1).

The patient, not expecting talk since the conversation is not mutually constituted, does not hear or understand the question, thus producing a next turn repair initiator, "Hm?" (2). With her focus now on the counsellor as she repeats the question (3), Letitia successfully interprets the repetition and replies accordingly (4) to which the counsellor responds with a third part in accepting the answer with "Aah" (5). During interval 6, as the researcher is closing the door

behind her, the counsellor takes her seat across Letitia, initiating mutual alignment, to which Letitia smiles and nods as a display of her readiness to start the counselling session.

Interpreting this action correctly, the counsellor responds by announcing the commencement of the consultation by using the discourse marker, “Okay” (7), to which Letitia nods again in acknowledgement (8). The counsellor then follows with a pre-sequence in the form of a demand with the intention of getting Letitia’s attention: “Look here” (9). This is not meant literally and is not used as a deictic reference, but rather as a request for Letitia’s attention and an announcement that a sequence will be initiated next. Again Letitia reacts by providing a display of reciprocity and attention (10) and maintains eye contact together with appropriate hearer signals in junctures between the speaker’s introductory utterances (11-14).

After this introduction, the counsellor provides another type of pre-sequence in providing an indication of the kind of information that is to follow. By saying “So, • uuh • • what we’re going to do now/ what will happen now, right? • • We will just uuh” (15), she connects pieces of discourse by indicating that the sequence that is to follow will involve procedural information regarding the structure of the session. As she begins this sequence with “We will just uuh”, Letitia interrupts her talk by taking the speaker turn during the counsellor’s unfinished sequence, and asks whether she can move her seat forward (16). Although she interrupts the counsellor’s speech, Letitia’s untimely production of a first part of an adjacency pair is triggered by the circumstances in which it appears she cannot properly hear the counsellor. By interrupting her, Letitia might have pre-empted a conversational breakdown (or a repetition of the violation of Grice’s maxim of manner) later in the session in which alignment could have been impaired because of mishearing which would have led to another repair sequence. Once they adjust the seating, this potential breakdown is overcome and the counsellor continues with the sequence in intervals (25-26): “• What we/ • What is going to happen now, right? • • We will just quickly do thee • • the HIV test, right?”

5.3.4 Summary

Opening sequences in pre-test VCT counselling sessions are generically found to be initiated by the counsellor with either a first pair part in the form of a summons to get the attention of the hearer, or a greeting for which a second pair part is produced by the patient. Following this initiating sequence a combination of turn-types is observed in the form of counsellors producing (i) questions inquiring how patients are doing, (ii) informative statements in which

they introduce themselves, or (iii) questions/statements regarding the reason behind the patient's visit.

Below a rough formal model is given of the generic turn-types found in the opening sequences of the data as explained above (which does not include the deviant cases in which the opening sequence is initiated by a question). Where *C* and *P* indicate the participants: counsellor and patient, *DM* is short for discourse markers, *S* for summons, *Gr*, greeting, *R*, response, *Intro*, introduction, *Q*, question, *A*, answer and *Stat*, statement. As explained above, all of these sequence types were found consistently throughout the opening sequences, but varied in sequence and amount.

$$[C:(DM)(S)(Gr) > (P:R) > C:Intro > (P:R) > C(DM)(Intro)Q > P:A (> C(Intro)Q > P:A) > C:Q/Stat\dots]$$

5.4 CLOSING SEQUENCES

As mentioned previously (cf. 3.3.4.4), the act of bringing a conversation to a close is collaboratively managed and negotiated by participants. This collaboration clearly takes the form of the counsellor as director of the initiation of the closing sequence as well as the development of the different turn-types throughout it. Discourse markers are generally used in indicating the start of this new and final sequence, and the sequence tends to end with another discourse marker uttered by the counsellor, or the production of a second pair part of an adjacency pair uttered by the patient. In this explanation, the generic features of closing sequences will first be given, followed by illustrative examples (excerpts c) to e)) below.

5.4.1 Generic features

The collaborative action of bringing a medical consultation to a close in doctor-patient consultations as a conversation is structured around the patient's focus on taking leave from the doctor. The patient in the type of medical conversation found in this study, however, is not taking leave from the counsellor or "step[ping] from a state of mutual involvement ... realign[ing] [her/his] responsibilities and obligations and rid[ding] [her/his] actions and activities of interactional consequence" (Heath, 1986:128-129, cited in West, 2006:381). The fact that the closing of pre-test VCT counselling sessions does not end in the patient taking leave from the counsellor, makes this discourse genre different from other medical conversations. What does come to an end, however, is the pre-test counselling session as a

conversation which then makes way for the initiation of the test itself, followed lastly by the post-test counselling session as a conversation in itself. This can be attributed to why, as opposed to taking leave from a doctor after a primary care visit, no cases of counsellors and patients bidding each other farewell with a “terminal exchange” (Schegloff & Sacks, 1973) are found in the data.

The same as with the opening sequences, each closing sequence in the data is initiated by the counsellor. The behaviour of the patient thereafter is always collaborative in that s/he agrees with the counsellor and follows requests. During instances in which counsellors inquire as to the patient’s understanding or whether s/he has any questions, there are no cases in which a patient initiates a previously unmentioned topic. This way in which actions are accomplished is in accordance with the previously mentioned roles inherently taken by the participants: the counsellor as leader in controlling the structure, versus the patient as follower. Another generic feature of the initiating utterance, is the fact that each one starts with a discourse marker: “Okay” or “So” (“Okay •• so •• we will just first sign your form” (BRF3) / “So we are now going to ...” (AMI1) / “So that is it” (BRF2). In this way counsellors indicate the transition between the question-answer (or educational phase) and the closing sequence. Two deviant cases in this regard are illustrated in 5.4.2.

After closer inspection the closing sequences were found regularly to follow on either the last question of the questionnaire, a summary of the test procedures provided by the speaker, or both. The closing sequence then generally consists of a combination of the following utterance types listed from most to least general:

- (i) Requests/instructions. At a point in every pre-test VCT counselling session a counsellor requests the patient to sign the consent form and instructs the patient where or how to sign. E.g. “Could Auntie sign this form for me or give a thumb print here, right?” (BRF2) / “You must just come sign the form here for me. •• Come sign here” (BRM2). This is the most frequent utterance type and is found in ten of the sessions. In each instance, this request or instruction takes the form of the counsellor asking the patient to sign the consent form. This is typical to closing sequences of pre-test HIV sessions in that according to protocol, the counsellor is not permitted to do the test without this written consent.
- (ii) Procedural information. Often counsellors provide information regarding the logistics around the following procedures or what can be expected as well as elaborations thereof. E.g.,

“... we're going to to uhn HIV test and then they / then I'm going to take you back to nurse Sonja” (AMI1) / “Okay so he's be/ we are now • also going to do a finger pricking with him” (AMI4)/ “We're going to roll fifteen minutes of the time there” (AAA1). This utterance type is the second most occurring utterance and occurs in nine conversations.

(iii) Questions. Excluding tag-questions uttered at the end of statements or requests, one counsellor clearly asks his patients whether they understand everything, or have any questions. E.g., “So you understand everything, Leon?” (BRM2) / “Are there more • questions that you don't know • • that you want to know?” (BRF2) This utterance type only occurs in four counselling sessions, three of which is conducted by the same counsellor, Charles. This indicates personal counselling style as he is a thorough counsellor who regularly asks patients whether they understand, have any questions, or are doing okay, and can therefore not be identified as a general feature of the conversation type.

(iv) Introductory phrases. In some cases, the counsellors introduce the tests or other information applicable to the actions that will be taken during the testing phase. E.g., “• These are the tests, how they look Nina.” (AAA1) / “We use this • • • and then this one...” (BRF1). This type of introductory utterance is only found in two sessions and will therefore not be categorised as a generic feature of closing sequences.

(v) Making arrangements (Schegloff & Sacks, 1973:90). This is only found in one conversation. In a mother-infant counselling session, the infant is too young for the finger prick test. In this case, blood must be extracted from the heel of the infant, which needs to be sent to the laboratory for testing. Here, as is generally found in primary care visits, the counsellor refers to a future visit during which the patient will be counselled again when she returns to the clinic for the test results. E.g., “I'll see you again in some time when you come and get your baby's results, right?” (AMI3).

What is found at the very end of these sequences, however, varies. While in some cases the last utterance is that of the counsellor informing the patient that she will be escorted back to another nurse after the test, others end in adjacency pairs with the counsellor uttering “Thank you, right?” and with the tag-question, prompts the patient to respond with “Thank you”, as well (BRM2). In some cases, patients reply “Okay” to utterances provided by counsellors for instance “See you in some time when you get your baby's results, right?” (AMI3) or “Just wait here, Uncle” (BRM1). In most cases, however, it is the counsellor uttering the last words,

to which patients do not respond: “Okay” (BRF1) / “There it is” (AMI2) / “Thank you. Okay” (AAA2) / “If it’s all right, hey?” (AAA1).

5.4.2 Deviant cases

There are firstly two cases that deviate from the general observation that utterances initiating closing sequences usually start with a discourse marker. This includes a session in which the closing sequence is preceded by a ten second writing period on the side of the counsellor after which she omits this kind of transition phrase and follows with an instruction “Your full name and your surname • and sign here then.” The discourse marker could be omitted due to the long pause between these pieces of discourses. In this case a different kind of discourse marker, “then” is used in order to orientate this speech to previous discourse. By saying “then”, the counsellor means that this action follows another action. The second instance is at the end of a counselling session in which a mother tests her infant. At the time that the last question is asked and answered, the child is making such a noise that both the mother and the counsellor are addressing him in trying to calm him down. Within this distraction, the counsellor moves straight from writing down the answer and addressing the boy, to the request: “Can you, can you ... Can you please sign here for me • that you give your permission?”

The most remarkable feature of the closing sequences found in the data is the way in which patients submit to the counsellor as leader who guides the development of the conversation. To restate, all the closing sequences were found to have a combination of requests or instructions (that patients then carry out) and procedural information provided by the counsellor (to which patients do not respond often). The closing sequences in the data prove to be generic in this way with an exception of one pre-closing sequence (cf. section 3.3.4.4) initiated by a counsellor that results in a patient mentioning a previously unmentioned mentionable which is described in excerpt e).

5.4.3 Examples

The excerpts provided below aim to illustrate the generic way in which the counsellor takes an active and the patient, a passive role. This conversation is between a referred patient, Maggie, and Charles in clinic B. Charles is the most thorough of the counsellors in that he is the only counsellor who regularly asks the patient whether they understand, etc. In order to avoid drawn-out pieces of data, excerpts will be provided in c) and d) overleaf.

c) *Maggie (BRF2) with Charles*

	145 [05:44.4]	146 [05:46.4]	147 [05:46.7]	148 [05:47.5]	149 [05:47.7]
C[v]	• • en ons doen die SDI toet-	sie.	└Verstaan Antie dit?		• Sal Antie die
C[FP]	STI				Sal Antie die vorm vir my
C[ENG]	• • and we do the SDI tes-	t.	└Does Auntie understand?		• Could Auntie sign this
C[SUP]	SDI: EP				rising intonation at end
P[v]		Hm̃.		Hm̃.	
	..	150 [05:50.9]	151 [05:51.1]		152 [05:53.3]
C[v]	vorm vi' my kan teken of die duim		• Ek gat nou dit doen. • En en... Maar u		<u>verstaan</u> alles
C[FP]	afdruk hier sit, nè?		Ek gaan nou dit doen.		
C[ENG]	kan teken...				
C[ENG]	form for me or give a thumb print		• I'll do it now. • And and... But you		<u>understand</u> everything
C[ENG]	here, right?				
P[v]		Hm̃.			
P[NV]		nod.			
	153 [05:54.0]	154 [05:54.9]	155 [05:57.7]	156 [05:57.8]	157 [05:58.9] 158 [05:59.7]
C[v]	wat ek vi' u sê.	• • Is daar nog • vrae wat u nie weet nie •		• wat u wil weet?	Niks nie.
C[FP]	wat ek vir u sê				
C[ENG]	that I told you	• • Are there more • questions that you		• that you want	Nothing.
C[ENG]		don't know •		to know?	
C[SUP]					
P[v]			Nee		• • • Neeē.
P[ENG]			No		• • • Noō.
P[SUP]			softly		soft
P[NV]			head shake		head shake

The counsellor summarises and repeats the same information a number of times and this might be due to the way he perceives the patient. Her depressed attitude is made apparent through her body language, lack of eye contact, articulation in general and the content of the few utterances provided. She does not contribute any hearer signals that shows true understanding throughout her session and she responds to 93% of the prompts (cf. sections 3.5.5.3 & 6.3.4) produced by the counsellor. Maggie is furthermore illiterate and needs to sign the consent form with a thumb print, which might implicitly contribute to the counsellor's perception of her understanding. He asks her to report on her understanding or additional queries three times in this excerpt of 15 seconds (147, 152-154, 156 & 158), as well as another time in the interval thereafter (“└You understand everything”).

In the following intervals, he asks her to confirm whether she gives consent to the tests and goes about the process of getting her thumb print. What is noteworthy about this process is the combination of instructions together with his narration of the actions as they occur.

d) *Maggie (BRF2) and Charles*

	... (163)	164 [06:10.7]	165 [06:13.3]
C[v]	net gou hie' die ••• duimafdrukke kry.	((1,2s)) Hou net so vir my daaar.	•• Ons gaan nou weer hier...
C[FP]			<i>Ons gaan nou weer hier...</i>
C[ENG]	just get the ••• thumb print here.	((1,2s)) Just hold like that for me theere.	•• Now again we're going here
	166 [06:15.3] 167 [06:26.6]	168 [06:27.5] 169 [06:27.8] 170 [06:33.2] 171 [06:34.3]	172 [06:37.1]
C[v]	((silence)) Hou net so daar	„druk.	((no speech)) 'Aa'sy. ((2s)) Dankiee. ((1,2s)) Laat ek net gou
C[FP]			<i>Daar's hy.</i>
C[ENG]	Hold just there	„press.	There you go. ((2s)) Thank youu. ((1,2s)) Just let me...
	.. 173 [06:39.5]	174 [06:41.5] 175 [06:47.0]	
C[v]	hier...	((no speech)) Dankie Antie Maggie.	
C[ENG]		Thank you Auntie Maggie.	
C[SUP]		Loud, rising intonation at end	
P[v]	((1s)) ((coughing, 0,9s))		

During this last (at least) 40 seconds before the end of the session, the role of speaker is only filled by the counsellor. The corresponding visual data to this excerpt shows how the counsellor takes Maggie through the actions by physically guiding her. After each request given by the counsellor above, the patient provides a “dispreferred” second part (cf. section 3.3.4.2) by not responding with compliance at all. In the first interval (163), the counsellor stands up and places the consent form in Maggie’s lap while instructing her to hold it there (164) while he takes the inkpad. During the silence (166) he takes her hand and presses her thumb against the inkpad. While he utters, “Hold just there ...” (167), he moves her hand towards the form and presses it against the form while emphasising the word “press” (168), and repeats the action on another space on the form during the following silence (169). With a positive tone he then announces that all is done in (170) after which he moves back to his desk. This sequence of actions can be seen to physically manifest the role differences between these participants as the counsellor guides and physically controls the passive patient’s body.

The following speech in 172 is aimed at the fact that he is on his way to open the door for the researcher and will not be taken into account in this analysis because this speech act – as it refers to the researcher as intruder – would not have occurred in the natural conversation. After this, he closes the pre-test counselling session by thanking Maggie. It is also noteworthy that she does not make eye contact with the counsellor or shifts her gaze in his direction throughout this excerpt. This might be interpreted as a form of passive depression which is apparently manifested through her body language continuously throughout the session. It may also, despite the counsellor’s non-patronising demeanour, be interpreted as shame on Maggie’s part, as she avoids eye contact or any mutual alignment.

In e) below, the only example of a possible pre-closing that results in the initiation of a new topic by the patient found in the data is given. Instead of acknowledging the speaker's announcement of the transition of phases between the educational and closing phase as is generally observed, the patient interrupts the counsellor by asking a question. This deviant case is remarkable as it is the only example found in the data where the patient takes an active role and challenges the structure created by the counsellor.

e) *Hans (BMMC1) with Mary*

	138 [03:59.9]	139 [04:01.8]	140 [04:04.1]	141 [04:04.8]
C[v]	• dan dis 'ie nodig 'ie, • • hm̃.	So dis nie nodig vir die CD vier telling...	• • • Okay.	((1,1s)) Ja • • ja ek
C[FP]	<i>dan dis nie nodig nie, hm̃</i>			<i>Ja, ja ek dink maar dis</i>
C[ENG]	• then it's not necessary, • • hm̃.	So it's not necessary for the CD four count...	• • • Okay.	((1,1s)) Yes • • yes I
P[v]	• dan dit • • doen niks hm̃.			
P[ENG]	• then it • • does nothing hm̃.			
P[NV]	<i>shaking head, then nodding</i>	<i>nodding</i>		
	..	142 [04:08.3]	143 [04:09.9]	
C[v]	dink ma' dis ma' net al, • ons	gan nou net • • hm̃. • Okay.		
C[FP]	<i>maar net al, ons</i>	<i>gaan nou net, hm̃. Okay.</i>		
C[ENG]	just think it's all, • we	are now just going to • • hm̃. • Okay.		
P[v]		Ekskuustog • ((unint., 0,4s)) • ((unint., 0,3s))	• • As ek nou/ • Gestel ek is nou MIV	
P[ENG]		Excuse me • ((unint., 0,4s)) • ((unint., 0,3s))	• • If I'm/ • Say I am HIV	
	144 [04:13.0]	145 [04:13.8]	146 [04:14.2]	147 [04:18.2]
C[v]	Hm̃.	• Hm̃.		• • • ô/ ja ons doen ma' nog
C[FP]				<i>o/ ja ons doen maar nog</i>
C[ENG]	Hm̃.	• Hm̃.		• • • o/ yes we still do,
P[v]	• positief	• • maar ek wil nou die • besnyding doen. • • Dan doen julle nog altyd?		
P[ENG]	• positive	• • but I want to do the • circumcision now. • • Then do you still do it?		
	..	148 [04:23.9]	149 [04:24.3]	
C[v]	altyd, mar ons kan/ • • a/ ons kan nie ve'dag doen nie, • • nè?			As ons nog uitvind, • ons moet mos
C[FP]	<i>altyd, maar ons kan/ a/ ons kan nie vandag doen nie, nè?</i>			
C[ENG]	but we can/ • • a/ we can't do it today, • • right?			If we still find out, • we must first see • how far
P[v]		Ooh̃.		
P[ENG]		Ooh̃.		

The beginning of the excerpt (138 & 139) contains the last two utterances of the counsellor's information-giving sequence. She then brings the educational phase of the counselling session to an end by announcing that she thinks that is all that needs to be covered (140-141), pauses and carries on with the beginning of the next sequence by starting it with procedural information "we are now just going to ..." (142). The patient, however, understands the pre-closing initiation and produces an interruption marker (Sacks et al., 1974:724) or courtesy phrase (Schegloff 1968:1080), "Excuse me" (142), in order to open a topic of concern. Through taking the turn by means of self-selection and interrupting the counsellor, this action

violates the basic conversational rule of one party talking at a time. This turn-taking error is then dealt with by the counsellor who pauses, uses a filler, and acknowledges Hans' action by saying "okay" (142). She then prematurely stops her utterance, an action used as a device for repairing overlapping talk, and yields the turn to Hans, who utters a question (143-146). After she acknowledges ("oh") and answers the question (147), Hans, who now changed his role to questioner through this action, indicates that he is satisfied with the answer provided with a newsmaker (148).

An opportunity for the chaining rule (cf. section 3.4.1.1), through which the counsellor (now answerer) would normally permit the patient (now questioner) to retake the floor after an answer is provided in order to ask another question, is not awarded. Instead, the counsellor selects herself to the speaker role in elaborating on her answer (149) as she probably assumes that Hans does not have another question. In this way, she regains her role as leader of the discourse in controlling the course of the conversation.

5.4.4 Summary

Closing sequences in pre-test VCT counselling sessions are generically initiated, organised and guided by the counsellor, with the patient sometimes signalling her/his alignment or understanding, or following instructions. There is only one instance in which a patient challenges the structures implemented by the counsellors. With the exception of one thorough counsellor who consistently asks patients whether they understand or have any questions, there is only one other counselling session in which the counsellor asks a patient this kind of question during the closing sequence. For this reason, question-answer pairs are not included in the general closing sequence schema below. Although some closing sequences are shorter or longer, the formal model below is a suggested representation of the generic progression found in closing sequences. Below, *R* and *PI* indicate requests and procedural information respectively.

$$[C: DM+R(/PI (> P:R) > C:(DM)R (>P:R))]$$

5.5 QUESTION-ANSWER SEQUENCES

As probably one of the most common examples of an adjacency pair (cf. section 3.3.4.2), the expectation of an answer after a question has been produced is what prompts the asker to relinquish the turn to the next speaker. A systematic consequence of the organisation of turns

(especially in these adjacency pairs) is that it “obliges its participants to display to each other, in a turn’s talk, their understanding of other turns’ talk” (Sacks et al., 1974:728). In producing the second part of the pair, or answer in this case, a speaker can indicate her/his understanding of a prior speaker’s intention, or in the case of misunderstanding or mishearing, make this conversational problem known. The production of this second pair part then furthermore enables the prior speaker to judge whether her/his intention was interpreted correctly or not. These adjacent utterances (as opposed to a one-utterance sequence) therefore enable participants to maintain successful communication in that the sequential articulation and interpretation of understanding throughout conversation can then be used to confirm mutual understanding through which repair sequences can be initiated in case of communicative failure (Schegloff & Sacks, 1973:75). While a display of understanding is then available for a co-participant, it is also valuable for the analyst as it can be used as a “resource for the analysis of prior turns and a proof procedure for professional analyses of prior turns” (Sacks et al., 1974:729).

As stated earlier, question-answer sequences (cf. section 3.4.1.1) are typical in medical consultations in general, but what is apparent in pre-test VCT counselling sessions, is the lack of question-answer sequences used in the way described above. According to the overall structure of this conversation, question-answer sequences occur twice and are both mostly yes/no or short answer questions in which knowledge is not tested. The first of these sequences containing question-answer responsive cycles is at the beginning of the session, after the opening sequence in which the counsellor makes small talk or asks the patient administrative or history-taking questions that are subtype specific (like asking mothers testing their infants about their PMTCT medication, etc.) or whether s/he is knowledgeable about HIV/AIDS.

The second occurrence is after the educational phase. Here, counsellors ask questions on the consent form which are the same in each session. These questionnaire-type questions do not test understanding or knowledge of the patient as it includes questions about the patient’s health. The turn-taking during this question-answer session is more consistent as it consists of questions for which answers must be provided in order for the conversation to carry on throughout which the counsellor applies the ‘chaining rule’ (cf. section 3.4.1.1). In the cases where patients do not provide an answer, the counsellor repeats the question. Additionally, throughout the conversation, especially during the information-giving sequences, counsellors

ask questions that prompt patients to give feedback on whether they are following, understanding or doing all right. These take the form of “Do you understand?” or “Are you okay with that?”.

These sequences in pre-test HIV test conversations are typically known to be controlled by counsellors not only on a structural level, but also regarding the content of the answer, as will be illustrated below. Another generic feature of questions asked in this specific type of conversation is the fact that counsellors often produce a barrage of questions, or questions directly followed by other speech which leaves no space for the patient to respond.

This analysis will focus on the kind of administrative questions in which history is taken (5.5.1), the questions in which patients’ knowledge of HIV should be solicited (5.5.2), as well as questions throughout the conversation in which the counsellor checks in on the patient in some way (5.5.3). In each case, as has been argued throughout this section, a thread of counsellor-centred behaviour is apparent, and will be illustrated by means of excerpts.

5.5.1 History-taking

A remarkable and general feature of this kind of question-answer sequences within pre-test VCT counselling sessions is the way in which counsellors formulate questions. Questions in the forms of statements are often found which appear to prompt patients to simply agree with the statement, rather than provide an answer of their own. In one session, for example, the counsellor and patient are talking about the patient’s medication during and after giving birth. Characteristically, the counsellor is leading the conversation: “Okay did you drink your pills correctly? ... Until you went into labour you did ...” (AMI1). Although the first question is appropriate, the counsellor provides an answer in the second statement, to which the patient responds affirmatively. These types of questions are convenient for the patient since they are not challenged to produce their own answer. Here one must consider the way in which utterances are packaged might influence the answer provided. If an alternative, objective question were asked, such as “Until when did you drink your pills?” or “When did you stop taking the pills?”, a different answer might be provided by the patient.

This carries on: “Okay. • • After you gave birth • • • you • came to the clinic with him. • • And • you continued drinking the syrup, • • then he was still drinking from the breast.” During this statement, the patient provides positive hearer signals affirming the information given,

without the need to produce her own answers, as no questions are urging them to do so. Another example of this kind of phenomenon is presented in excerpt f) overleaf.

f) *Alison (AMI1) and Gretha*

	101 [02:15.8]	102 [02:16.8]	103 [02:18.1]	104 [02:18.8]	105 [02:19.5]	106 [02:20.3]
C[v]	•• Alison.		•• Okay.			•• Okay. ((1,2s)) He' jy
C[FP]						Okay. Het jy die
C[ENG]						•• Okay. ((1,2s)) Did
P[v]	•• Ek moe' nou	• môre vir als • kom.	•• Moe' nou	môre begin,	• op 'ie pil.	
P[FP]	<i>Ek moet nou</i>		<i>Moet nou</i>		<i>op die pil.</i>	
P[ENG]	•• I must now	• come tomorrow • for	•• Must now	begin tomorrow.	• on the pill	
P[SUP]		everything.			soft	
	..	107 [02:22.8]	108 [02:24.2]	109 [02:25.8]	110 [02:26.9]	111 [02:27.8]
C[v]	die pille ge-	<u>los?</u> ((1,1s))	Hoe lank is jy sonder 'ie pille?			•• <i>Lank.</i>
C[FP]	<i>pille ge-</i>	<i>los?</i>	<i>Hoe lank is jy sonder die pille?</i>			
C[ENG]	you	<u>leave</u> the pills? ((1,1s))	For how long have you been without the pills?			•• <i>A long time.</i>
P[v]				• Hñm hñ.		
P[SUP]				unsure		
P[NV]		<i>nodding</i>				<i>nodding</i>

Again the counsellor's role as the one with power is established and can be seen in the fact that she interrupts the patient's speech in intervals 101 and 103. The way in which she says "Alison" and "Okay" is an example of an interruption as she is trying to regain the speaking turn, which Alison then relinquishes after she finishes her sentence. What is further interesting to note is the development of the question-answer sequence that stretches from interval 108 to 111. After initiating the first pair part (108), Alison does not provide an answer, but rather shows that she is unsure. The counsellor then provides a possible answer (110), which Alison then simply accepts by nodding (111).

The excerpt overleaf provides another example of a counsellor who inflexibly follows her own agenda, despite the patient's need to share a story of trauma. This again emphasises that the counsellor's main concern is following protocol, regardless of the needs of the patient.

g) *Letitia (BRF3) with Mary*

	229 [07:45.5]	230 [07:46.0]	231 [07:47.0]	232 [07:47.3]	233 [07:47.9]
C[v]	• Oh		• Oh	Wat was	jou uitslag • toe was jy ge/ toe
C[ENG]				What was	your results • when you were t/ when you
P[v]	• net	een seun oor,	eenn	twintig.	
P[ENG]	• just	one son left,	twenty	one.	
	..	234 [07:50.2]	235 [07:50.5]	236 [07:51.7]	237 [07:52.2] 238 [07:52.7]
C[v]	het jy getoets het	<u>daai</u>	jare, wat was die uitslag?		Was jy sk...
C[ENG]	were tested	<u>those</u>	years, what was the result?		Were you cl...
P[v]				Uh-	uuh <u>uitslag gewees?</u>
P[ENG]					<u>results?</u>
	239 [07:53.5]	240 [07:54.2]	241 [07:54.4]		
C[v]	• • Skoon?	Of...			
C[ENG]	• • Clean?	Or...			
P[v]		Uh	My my eerste/ my eerste kind • • • het uh geelsig gehad toe't it niks bloed daa'		
P[FP]			<i>My my eerste/ my eerste kind, het uh geelsig gehad toe het dit niks bloed daar</i>		
P[ENG]			My my first/ my first child • • • was jaundiced then there was no blood there		
	242 [07:59.4]	243 [07:59.9]		244 [08:02.2]	
C[v]	Aah.			Okay.	
P[v]	nie.	• • • Toe gee hulle vi' my bloed, lank		gelê met dit.	
P[FP]		<i>Toe gee hulle vir my bloed, lank</i>			
P[ENG]		• • • Then they gave me blood, long time	I lay with that.		
	245 [08:03.4]				
C[v]	Ek meen wat was jou MIV • • uitslag • daai tyd, • hulle't mos vi' jou getoets, nè?				
C[FP]	<i>Ek meen wat was jou MIV uitslag daai tyd, hulle het mos vir jou getoets, nè?</i>				
C[ENG]	I mean what was your HIV • • results • that time, • they tested you, right?				
	246 [08:08.7]	247 [08:08.9]	248 [08:10.6]	249 [08:10.9]	250 [08:12.4]
C[v]		En toe het hulle vi' jou gesê of	<u>het</u>	jy die MIV VIGS of het jy <u>nie?</u>	
C[FP]		<i>En toe het hulle vir jou gesê of</i>			
C[ENG]		And then they told you either you	<u>have</u>	the HIV AIDS or you	<u>don't?</u>
P[v]	Jā.				
	251 [08:12.7]		252 [08:16.5]	253 [08:16.8]	
P[v]	• • Nee ek het 'ie... • • Toe sê hulle v' my • • • my kind		sal	nog lewe, • • mar het	
P[FP]	<i>Nee ek het nie... Toe sê hulle vir my...</i>			<i>nog lewe, maar het ek nou die</i>	
P[ENG]	• • No I don't have... • • Then they said to me • • • my child		will	still live, • • but I infected the	
	..				
P[v]	ek nou die twee kinders angesteek • • • ((unint., 0,5s)) • uh geelsig gehad, ((1,1s))				
P[FP]	<i>twee kinders aangesteek. uh geelsig gehad, toe steek hulle nou vir hulle twee ook aan. Toe het</i>				
P[ENG]	two children • • • ((unint., 0,5)) • uh had jaundice, ((1,1s)) then they infected the two of them too. • • Then				
	..	254 [08:25.3]	255 [08:25.5]	256 [08:26.1]	
C[v]				• • • Mar die MI-	
C[FP]				<i>Maar</i>	
C[ENG]				• • • But the HI-	
P[v]	toe steek hulle nou vi' hulle twee ok an. • • Toe't	niks	bloed 'ie.	• • • Toe lê ek	
P[FP]		Niks	<i>bloed nie.</i>		
P[ENG]		no	blood left.	• • • Then I was for a	
	257 [08:27.3]	258 [08:27.7]	259 [08:28.5]	260 [08:30.0]	261 [08:31.1]
C[v]	V VI-	GS.	Mar • • die MIV VIGS,		• • Het jy nie dit 'ie?
C[FP]			<i>Maar</i>		<i>Het jy nie dit nie?</i>
C[ENG]	V AI-	DS.	But • • the HIV AIDS,		• • Don't you have it?
P[v]	lank	wee' in die hospitaal.		• • • Hhnh.	
P[ENG]	long time	again in the hospital.			
P[UP]				negative	
P[NV]				<i>shaking head</i>	

The talk preceding this excerpt is one in which Letitia pursues the topic of her children's health. This illustrates the counsellor's insistence on returning the conversation to what she regards to be the desired topic. Her contribution implies that what the patient is imparting, is irrelevant to her schema of the conversation. That Letitia is not familiar with the bigger picture in the sense that she doesn't grasp what the counsellor is trying to achieve, may explain her elaboration on the circumstances in which previous tests may have been taken. They are in fact both indirectly saying something that they find to be relevant, which the counsellor fails to recognise. It therefore appears as if the counsellor is missing the relevance of the patient's contribution, or the patient misses what the topic is about and moves into a new and familiar terrain, which explains why the counsellor is trying to redirect the conversation.

In this aim to redirect the talk, the counsellor self-selects by starting to utter a question that overlaps with the last two words of Letitia's utterance (232). This question is also preceded by two continuing markers (229 & 231) that could serve as a foreshadowing of the counsellor's intention of taking the floor. As she starts her utterance, Letitia yields her turn (232) in order to repair the violation of the one party talks at a time rule (Schegloff & Sacks, 1973). The turn that follows is designed in such a way to return to the main topic as the counsellor asks Letitia what her results were when she was tested at that time.

What follows holds examples of repair initiations, sentence abortions and misunderstandings as each participant pursues her own agenda with a clear lack of intersubjective understanding. The fillers uttered by Letitia (236 & 237) seem to convey acknowledgement of the question and could be produced out of obligation to say something due to the expectation created by a completed question. After uttering two fillers, Letitia initiates a repair by repeating a phrase she did understand, "results?" (238). While this is happening, the counsellor offers possible answers that Letitia can use in providing a response. Despite this attempt to aid, the counsellor is forced to abort the utterance in order to yield the turn to the patient (237-238).

The counsellor then attempts to prompt the answer she is looking for (239) but aborts this attempt as Letitia takes the floor in providing an answer that does not fit the question (241). Here, the counsellor should be advised to take the role as listener as the patient needs to be heard about something that is more than a positive or negative outcome of a test in her past. The counsellor could pick up that the answer gives other information, allow the patient to tell

her story, and then take initiative in steering the patient towards what she wants to know without silencing her.

Throughout Letitia's following speech, the counsellor provides hearer signals and waits for a transitional point as to not interrupt the patient to initiate another repair phrase. Her first words, "I mean ..." (245) indicates that after listening to Letitia's response, she has judged her understanding as insufficient and wants to make her intention clear. She follows with an unambiguous question (245) with a pause after "HIV" to emphasise the test she is talking about in an attempt to resolve the misunderstanding. She also ends the sentence with the tag prompt, "nè?" to solicit an answer from Letitia. Letitia then answers "yes" (246) after which the counsellor provides another clear question in which emphasised words (248 & 250) are used to aid in bringing across meaning. Again, Letitia waits until the turn is allocated to her and she produces an inappropriate answer (251-255).

In an exasperated effort to solve this clear misunderstanding, the counsellor exerts her role of authority in this relationship by repeating the same sentence ("But the HIV AIDS") with the aim to return to the topic. The first utterance overlaps with Letitia's ongoing speech (256-258) and the second is uttered again after Letitia concludes her utterance (259). After this repetition, Letitia replies with a negative "Hính." In order to clarify, the counsellor asks "Don't you have it?" to which Letitia answers with the same "Hính." Although these answers are still not an indication of true understanding, the counsellor carries on by continuing with a string of questions.

5.5.2 Soliciting of knowledge

During the first question-answer sequence in the conversation, different types of questions are asked throughout the data. As one of the aims of the pre-test VCT counselling session as conversation is to make sure that patients understand the necessary HIV/AIDS-related information, one would expect an attempt on the side of the counsellors to assess the patients' extent of knowledge on the subject and formulate the information-giving session to follow according to the knowledge or lack thereof articulated by the patient.

Out of the 14 conversations, there are only three instances in which the counsellor formulates a question that will achieve this aim: "What do you know about HIV?" which is asked twice, and "What is HIV?". The other questions, "Do you know what is HIV?" and "Do you have the information about HIV?" are simple yes/no questions that do not prompt a patient to

provide her/his knowledge as s/he can simply answer “yes” without being prompted further. In cases when patients answer affirmatively (“Yes I have that knowledge” or when a patient told the counsellor that s/he has attended a workshop on the subject), the counsellor continues with the same string of information, almost on a word-by-word basis, as is produced during other counselling sessions. This type of question occurs in eight out of the 14 conversations. Three conversations then completely lack any kind of solicitation of the patient’s knowledge on the subject, with one where a counsellor rather announces that she will start the information-giving session (“Now I’m going to give Uncle the information”) without taking into account the patient’s knowledge.

h) Letitia (BRF3) with Mary

	87 [02:17.1]	88 [02:18.2]	89 [02:22.1]
C[v]	•• Ookay.	((3,3s)) Okay.	((3,4s)) Kyk hier. •• Sê vi' my of • weet jy • vaan • informasie oor MIV VIGS?
C[FP]		<i>Sê vir my of...</i>	
C[ENG]		((3,4s)) Look here. •• Tell me if • do you know • about • information about HIV AIDS?	
P[v]			
P[ENG]			
	90 [02:30.1]		
C[v]	••• Soos •• wat is MIV VIGS of • hoe word VIGS versprei? ••• Het jy daai informasie? • Of kan ek vi' jou bietjie vertel van dit? ••• Kan ek vi' jou bietjie sê?		
C[FP]	<i>Of kan ek vir jou bietjie vertel van dit? Kan ek vir jou 'n bietjie sê?</i>		
C[ENG]	••• Like •• what is HIV AIDS or • hoow AIDS is spread? ••• Do you have that information? • Or can I tell you about it? ••• Can I tell you a bit?		
	91 [02:39.9]	92 [02:42.3]	
C[v]		•• Kyk hie', •• die MIV VIGS, nè?	
C[FP]		<i>Kyk hier,</i>	
C[ENG]		•• Look here, •• the HIV AIDS, right?	
P[v]	((1,5s)) uuh •• ((unint., 0,4s))?		
P[NV]	<i>lifts chin, raises eyebrows, questioning</i>		

As mentioned above, all the questions formulated in this excerpt are yes/no questions through which the counsellor does not inquire about the patient’s actual knowledge of HIV/AIDS, but rather whether she has any knowledge whatsoever. It seems as though the counsellor goes through the motions by ticking the boxes of what should be covered according to protocol, regardless of the patient and her/his knowledge. Furthermore, the counsellor repeats the same question in three different way to accommodate the addressee. She introduces the question in 89, on which she elaborates for extra clarification in 90, followed by two questions repeated in different words to provide additional support to a recipient she might perceive to be struggling to follow the conversation.

Regardless of the counsellor's efforts to clarify the question by repeating it more than once and in more ways than one, the patient's reply in which she lifts her chin and raises her eyebrows in a questioning way, is a clear indication of misunderstanding (91). From this moment, misunderstanding is clear for the observer, but not confronted by the participants. The counsellor carries on by first summoning Letitia's attention, "Look here" (92), after which she embarks on almost four minutes of information-giving in which the turn is not relinquished and the only hearer contribution found are continuers that occur through the back channel in the form of non-speech ("hmm") and nodding.

5.5.3 Checking-in

Throughout different kinds of sequences found in this type of conversation, counsellors check in with the patients by for example asking them whether they understand or are comfortable. Examples here often show that (i) no space is provided after the first pair part in which the patient can respond, or, as shown before, (ii) subjective statement-like questions are formed which steer patients towards a specific response. Both of these occurrences indicate conversations that are not patient-centred as (i) patients are denied a speech turn in the production of a second-pair part response, and when they are given this natural opportunity, (ii) patients are encouraged to give a certain answer.

After a counsellor provides a summary of procedural information in a closing sequence, he asks the patient if she understands without providing a space in which she can respond, which leads to an overlap in speech during which he sums up with "So that is it" while she responds to the previous question with "Hm." By not providing a space in which the patient can answer his question, the counsellor breaks a basic rule of adjacency pair operation by not pausing after the completion of the first pair part in which the next speaker can produce the second pair part (Schegloff & Sacks, 1973:74).

An example of a question sequence in which the counsellor influences the response of the patient is also found during an information giving sequence. Here, the counsellor utters "So ••• so you're all right with that, right Mommy?" to which the patient responds, "Yes." Again, this is not essentially a question (i.e. "Are you all right with that, Mommy?"), but a statement uttered in the form of a question, in which the counsellor assumes the answer before it is given and to which no objecting responses are provided throughout the data.

5.5.4 Summary

While adjacency pairs such as question-answer pairs are helpful in gaining insight as to a participant's understanding or knowledge, the question answer sequences found throughout pre-test VCT counselling sessions are rarely used in this way. Three types of unproductive question-answer pairs (in terms of getting new information on patients' understanding) are found throughout this conversation type: (i) history-taking or administrative questions do provide productive answers that the counsellor does not already have, although the formulation of the questions sometimes influence the answer given, (ii) questions aimed at soliciting a patient's knowledge on a subject are found to be problematic in that they do not directly solicit the extent of patients' knowledge, and (iii) shorter / tag-questions through which the counsellor checks on the patient's understanding and well-being in that uniformity of positive responses is not necessarily reliable and counsellors do not always pose these questions with the aim of receiving and interpreting the answers.

Three apparent generic features are found throughout all these question-answer sequences in pre-test VCT counselling sessions. Firstly, questions generally solicit short or yes/no answers, which shows that counsellors do not often willingly relinquish the speaking turn. Secondly, counsellors package questions in such a way to influence the answer provided by the patient. Here statements can be made in question form, or possible answers can be provided by the counsellors themselves to which patients simply respond by affirming. Lastly, counsellors often do not provide a space in which a second pair part to a question can be produced. This might be due to the fact that most patients take a passive role in the conversation and that counsellors assume an answer before it can be given.

Patients are often "outsiders" in this institutional context in that they do not undergo this kind of counselling regularly and are not familiar with the protocols. What is unfortunately apparent, is the fact that counsellors expect this passive behaviour from all the patients, and accordingly take the directing role in each instance, without entering the conversation expecting a patient to behave differently, and even when they do, get directed through the same conversation and utterance structures.

5.6 INFORMATION-GIVING SEQUENCES AND HEARER SIGNALS

As part of their “grossly apparent facts” of conversation, Sacks et al. (1974:700-701) observe that turn sizes are not necessarily fixed and that various kinds of ‘turn-constructive units’ are used whether an utterance consists of one word or multiple sentences. The typical long monologue-style information-giving sequences produced by counsellors in this discourse genre is made possible by the repeated application of Sacks et al.’s (1973:704) rule 1c (cf. section 3.3.4.1) regarding the governing of turn taking: “[i]f the turn-so-far is so constructed as not to involve the use of a ‘current speaker selects next’ technique, then current speaker may, but need not continue, unless another self-selects.”

A fundamental assumption behind joint understanding in conversation is that it can be maintained within the turn-taking system. As discussed before, a current speaker can judge the hearer’s understanding of speech during the following turn when the roles are reversed and the previous hearer displays her/his understanding of preceding speech during her/his current speech (Sacks et al, 1974:728). Depending on the level of understanding displayed, the original speaker can then choose to react accordingly; while the conversation can continue if the hearer’s understanding is deemed appropriate, a repair sequence can be initiated if it is not. The progression of the conversation is therefore locally managed, turn-by-turn, which Heritage and Maynard (2006:12) call “*local determination*.”

As opposed to ordinary social conversation with frequent turn changes, the distribution of turn duration found in the discourse genre analysed in this study is far less balanced. As the pre-HIV-test protocol requires counsellors to cover a certain number of topics, the structure of the typical information-giving sequences tend to take a monologue-like form which does not leave much space for adjacency pairs being used as a kind of understanding-checking device. Consequently, this institutional discourse genre does not allow counsellors to monitor and judge hearers’ understanding through local determination as easily as in everyday interaction, but are left with feedback responses produced in the form of hearer signals.

5.6.1 Generic features

These information-giving sequences consist of narrative cycles that typically contain the following informative topics: ways of contracting HIV, advice on lowering one’s risk of contracting HIV as well as the nature of the virus which includes the concept of the CD4 count, what it means and how it works. Then information regarding the test is also covered as

counsellors inform patients what a positive or negative test result would mean. Other conversation subtype-specific information is also covered in which counsellors provide e.g. information regarding nutrition for mothers testing their infants, context-specific advice on how to prevent HIV transmission (like what to do if a fellow classmate is injured and bleeding on the school ground for the pre-adolescent girl), or information on why an HIV test is necessary (for the rape victim, for example).

What is then generic in these information-giving sequences on a structural level is that the patient does not take the floor due to the fact that the counsellor carries on self-selecting as the next speaker. This provides for the general presence of a concentrated amount of hearer signals since patients have to communicate via the back channel. Another highly occurring phenomenon from the side of the counsellor is the production of different types of prompts that encourage the production of these hearer signals. During these sequences the hearer is therefore found to be quite passive by either making no contribution, or hearer signals with various functions. The excerpts below provide typical examples of information-giving sequences and attention will be given to devices used by the counsellor as well as signals provided by the hearer.

As has furthermore been mentioned in the previous section on question-answer sequences, the information-giving sequences contain a more concentrated amount of checking-in devices in the form of prompts and tag-questions produced by the counsellor. How many occur within counsellors' talk, as well as the number of hearer responses to this technique will be highlighted in section 6.3.4. It should also be stated that these tag-questions and prompts are not always followed with an appropriate pause in which hearers can provide a response. With this being said, there are also many instances in which this type of opportunity is provided.

5.6.2 Examples

Since these sequences tend to be lengthy, only excerpts of one such sequence will be provided. The excerpts i) and j) are taken from a three-minute long information-giving sequence during a counselling session between a referred male patient and Mary in clinic B.

i) *Pedro (BRM1) and Mary*

	49 [01:32.6]	50 [01:33.9]	51 [01:36.2]	52 [01:36.4]
C[v]	lewe met MIV VIGS, nè?	•• Mar, •• dit is baie belangrik dat jy moet	<u>kyk</u>	na jou gesondheid, nè?
C[FP]		<i>Maar,</i>		
C[ENG]	lives with HIV AIDS, right?	•• But, •• it is very important that you must	<u>look</u>	after your health, right?
	53 [01:37.7]	54 [01:38.1]	55 [01:40.6]	56 [01:40.8]
C[v]		Soos •• uuhmm ••• Daar is	<u>geeen</u>	geneesmiddeling vir MIV VIGS, nè?
C[FP]				<i>geneesmiddel</i>
C[ENG]		Like •• uuhmm ••• There is	<u>Noo</u>	cure for HIV AIDS, right?
P[v]	Já.			
P[ENG]	Yés.			
P[NV]	<i>nodding</i>			

The counsellor announces the initiation of the information-giving sequence at the beginning of this sequence (that is not given in the excerpt) that “[she’s] just going to give [the patient] a bit of information about HIV/AIDS.” She does not check with him how much he already knows about the topic. A generic feature of which three examples are included in this excerpt, is the inclusion of prompts at the end of informative statements. This specific patient responds to the prompts the least of all the participants and of all of the “nè” prompts provided (49, 52 & 56), he only responds once (53). This affirmative hearer signal is interpreted as that he probably understands and agrees with the preceding statement.

j) *Pedro (BRM1) and Mary*

	...	98 [03:18.4]	99 [03:19.0]
C[v]	di die CD vier telling • as die toetse wys dat jy het MIV VIGS.	•• Dan,	as die toetse wys dat jy
C[FP]			
C[ENG]	th the CD four count • if the tests show that you have HIV AIDS.	•• Then	if the tests show that you
P[v]		• Ja jaa`	
P[ENG]		• Ye yees`	
P[NV]		<i>nodding`</i>	
	100 [03:20.2] 101 [03:20.4]	102 [03:23.3]	103 [03:24.4] 104 [03:25.1]
C[v]	<u>het</u>	'ie... •• so dis 'ie nodig om te die CD vier telling trugk.	••• ver- staan jy, Oom?
C[FP]		<i>nie... so dis nie nodig om te die CD vier telling trek.</i>	
C[ENG]	<u>don't</u>	have... •• so it's not necessary to take the CD four count.	••• you under- stand, Uncle?
P[v]		••• Jà jā`	Jaa.
P[ENG]		••• Yès yēs`	Yees.
P[NV]		<i>nod`</i>	<i>nod</i>

In this next excerpt, the hearer signals being provided by Pedro are observed to indicate that he already understands the information that is conveyed to him. It is not the first time the counsellor has spoken about taking the CD4 count and what it means, so one can assume that Pedro is following and understanding in this case. This alignment is indicated by repetitions of the affirmative hearer signal, “yes” and emphasised with nodding at the same time and can

be seen as a reaction to the speaker's violation of Grice's (1957) maxim of quantity (cf. section 3.2.1). Despite this expression of understanding, the counsellor continues moving down her checklist of topics that need to be covered.

What is further typical about the hearer signals provided throughout these information-giving sequences is that they are not produced with the intention of interrupting the speaker, but rather to show agreement (as in example i)), understanding and that the patient is still following the counsellor. Hearer signals, however, do not always occur in the form of nods and single word utterances. Hearer feedback within the back channel of the conversation often takes the form of possible sentence endings uttered at the same time or just after the counsellor's production thereof, showing understanding and also sometimes agreement. An example is provided in the excerpt below.

k) Mandy (AMI4) and Gretha

	140 [03:31.2]	141 [03:33.2]	142 [03:33.6]	143 [03:34.7]	144 [03:35.5]
C[v]	Dan gaan ons kyk of hy negatief is,		en of hy positief	is.	Ja.
C[FP]					
C[ENG]	Then we will check whether he is negative,		and whether he is positive	...	Yes.
C[SUP]	rising intonation		falling intonation		
P[v]		Hm.		Positief is.	
P[ENG]				Positive.	
P[SUP]		affirmative			

Mandy is a mother testing her infant. In this excerpt the counsellor is busy providing procedural information about the test. Positive feedback of understanding in which the hearer is not attempting to claim the role of speaker, but is still providing speech, can be found in the form of a repetition of the counsellor's last word, "positive" (143), immediately after it has been uttered. It can be argued, however, that the counsellor's tone and pause placement could serve as a prompt. By uttering an either/or type sentence, the counsellor breaks the utterance into two (140 & 142). This syntactical structure creates an expectation of the second part after the first has been uttered. Together with this, the counsellor uses intonation to support this expectation as the first part of the sentence ends with rising intonation followed by a pause, to make way for the expected second part of the sentence that is articulated with falling intonation. This kind of speech could be found in teaching as teachers might use this technique to prompt students to participate.

Although this prompting technique is only used by one counsellor and can therefore not be characterised as a generic feature of pre-test VCT conversations, it can be seen as another technique employed to prompt hearer participation. Although this would then seem to be patient-centred conversation, the fact that only short answers and hearer signals are being prompted, instead of expression of a patient's actual comprehension on the topic, proves otherwise. These hearer contributions in the form of phrases uttered are furthermore important as they are found throughout the counselling sessions. This is also covered in more detail in chapter six. Additionally, the other hearer signal in this excerpt (141) is also worth mentioning. Since it is produced during the pause after an expectation is created through syntax and intonation, it could be interpreted as a token of acknowledgement in that Mandy could mean to say "I am following, please continue" without interrupting the flow of the speech.

5.6.3 Summary

In this section attention is given to information-giving sequences as a significant type of conversational sequence found in pre-HIV test counselling sessions as a conversation. The most generic feature of these sequences is the fact that counsellors control the turn-taking process by mostly self-selecting as the next speaker. Not many opportunities for the patient to take the floor is provided, despite the frequent occurrence of tag-questions or prompts produced by the counsellors. These generic features make the occurrence of hearer signals a prevalent feature found in these conversations. The importance of examining this phenomenon is emphasised in this study, which is why an analysis of its frequency, function and contribution is provided in the following chapter.

5.7 SOCIAL CONCERNS

As a socially aware researcher, it is important to comment on the social concerns regarding the bigger discourse as reflected in the cases discussed above. As established early in this study, pre-HIV test counselling is a specific discourse genre with certain generic sequence-styles and characteristics. This specific structure is taught to counsellors in training as a strict protocol to be followed. In providing counsellors with this specific template according to which sessions should be conducted, the counsellor is then encouraged to dictate the conversational structure.

Within these strict constraints set out by the counsellor, patients are not often found to take the floor if it is not explicitly given to them. In this data, there is one moment where a patient (who takes the role as follower) pushes the structural boundaries set by the counsellor as speaker by self-selecting as speaker and taking the floor without being allocated the speaker's turn by the counsellor (who takes the leading or controlling role). In this way, one can speak of the agency of the hearer; the patient as hearer is left without agency in this discourse.

The fact that different patients provide different hearer signals throughout speech clearly shows that some hearers are already knowledgeable about HIV and AIDS while others show a clear lack thereof. What is found, however, is that hearers on both sides of the spectrum are treated in the same way. Hearers in the know sit through (yet another) information-giving session simply in order to get through this conversation as part of the process in order to get to the aim of the visit: the confirmation of their HIV status. Although hearer signals that indicate and reiterate understanding and knowledge are found, or patients inform counsellors that they are familiar with the information, the hearer is put through the same information-giving sequences as it is part of the counsellor's protocol. In some cases, the counsellor asks the patient to relay her/his understanding, to which the counsellor listens and responds accordingly, but in most cases the counsellor continues with the checklist regardless. In this way, it can be argued that counsellors enter the conversation with similar "listener models" (cf. section 3.2.5.1(ii)) for each patient, despite patients' indication of differences in knowledge.

When no clear understanding is shown, however, counsellors mostly continue giving information and patient understanding is scarcely judged by means of adjacency pairs. Since the clinics in this study have only one and two counsellors, it is understandable that the number of counsellors in comparison to the number of patients can contribute to pressure on the counsellor in order to counsel each patient. This (very real) pressure often results in counsellors trying to speed up the counselling process in order to serve all the patients. In doing this, counselling sessions tend to reveal a more HCP-centred, or more specifically a counsellor-centred approach in which soliciting patients' understanding (which is time-consuming) is not necessarily the main concern.

Perhaps at this stage a disclaimer is required that will mitigate implied criticism of some aspects of the VCT process as identified above. The program of counselling for vulnerable and limitedly resourced patients in the face of a devastating epidemic has been developed in

quite remarkable ways. Bringing in the intervention of counsellors who mostly come from the patients' home communities was an innovative response to an otherwise overwhelming task for the trained HCPs such as nurses and physicians. The system of VCT has aided in providing ART to a large and diverse group of people throughout urban and rural South Africa. The contribution of governmental and non-governmental organisations who provide and facilitate these services at clinics are vital. Additionally, and equally valuable, the training and employment of counsellors outside of the medical practice contributes to the eradication of previously uneven distribution of power within consultation, testing and treatment within VCT. Even in the authoritative position the counsellors have, they appear to be much more accessible than other HCPs who have quite excessive workloads already.

It is, however, apparent from the observation done in this study that from time to time patients indicate different degrees of already accomplished knowledge and understanding or the lack thereof, or that they require additional support that the counsellors are not equipped to provide. As an outcome of the study I therefore suggest that counsellors should be trained towards a more patient-centred approach, through which crucial resources that already show positive results could be managed more efficiently. In focusing on the agency of the hearer, for example, time might be managed more effectively and cases that need extra attention would more easily be detected and given the necessary kind of support.

5.8 CONCLUSION

This chapter set out to investigate the organisation of speech acts within pre-test VCT counselling sessions as a conversational subtype found in medical discourse. The generic structural form that these conversations take contains the following sequences:

Opening > (small talk) question-answer > information-giving > Question-answer > Closing.

The organisational structure of each of these sequences were then investigated in order to identify generic features in characterising this type of conversation. Throughout the analysis, evidence indicates a largely counsellor-centred approach to the conversation. The most important feature found throughout the sequences is the fact that one person has institutional power and does the most of the speaking and managing of conversation development while another, a stranger to the context, is in a vulnerable position and does very little talking in

taking the role of a participant who is expected to listen and absorb. As patients are observed to take a passive role in producing utterances only in response to a speech act produced by the counsellor, a conversational structure is created that limits the patient.

Table 5.1 overleaf provides a quantitative representation of the imbalance in verbal participation found during these conversations. The data is organised according to the words uttered by patients from highest to the lowest word count in relation to the full conversation. Nonverbal speech acts such as nodding and shaking of the head are not included. In the calculation of the total number of words uttered in each session, all pieces of verbal utterances are included (i.e. also non-speech items such as “hm” and “uh”), as well as aborted words or phrases. Unintelligible utterances are not included in the total as the number of words uttered in these phrases cannot be identified and are found in the speech of both counsellors and patients. The omission of these utterances is not believed to influence the numbers and statistics markedly. This total of verbal utterances is then firstly provided, followed by the total words (and percentage in terms of its contribution to the total words uttered) uttered by the counsellor as well as the patient. The statistics show an apparent imbalance with an average of 82.8% of words spoken by the counsellor versus 17.2% of that of the patient. With the exception of Leon (BRM2) at 47.6% contribution the total words uttered), all patient contribution is found to be under 33% with three patients (Nina (AAA1), Minnie (AAA2) and Nina’s mother (AAAM1)) whose verbal contribution is under 1%.

Table 5.1: Counsellor and patient verbal contribution in pre-test VCT counselling

Patient	Total words uttered	Total words uttered by counsellor	% of words uttered by counsellor	Total words uttered by patient	% of words uttered by patient
(BRM2) Leon	1392	730	52.4%	662	47.6%
(AMI4) Mandy	801	542	67.7%	259	32.3%
(BMMC1) Hans	1158	808	69.8%	350	30.2%
(AMI1) Alison	886	640	72.2%	246	27.8%
(BRF3) Letitia	1351	978	72.4%	373	27.6%
(BMMC3) Henk	1228	943	76.8%	285	23.2%
(BRF1) Jo-Anne	1779	1450	81.5%	329	18.5%
(AMI2) Louise	955	837	87.6%	118	12.4%
(AMI3) Chané	1284	1127	87.8%	157	12.2%
(BRF2) Maggie	826	729	88.3%	97	11.7%
(BRM1) Pedro	985	875	88.8%	110	11.2%
(BMMC2) Pieter	880	790	89.8%	90	10.2%
(AAAM2) Minnie mo ³¹	902	817	90.6%	85	9.4%
(AAAM1) Nina mo	1191	1183	99.3%	8	0.7%
(AAA2) Minnie	820	817	99.6%	3	0.4%
(AAA1) Nina	1187	1183	99.7%	4	0.3%
Average			82.8%		17.2%

Every one of the sequences investigated and reported on above were initiated by the counsellor. When considering the hearer as co-participant in both participants' collaborative attempt at mutual understanding (cf. section 3.5.1), one might argue that this type of conversation is autonomous in that the counsellor dictates its development. It is argued here, however, that even when the counsellor is dominant in terms of sequences' organisational structure, there is always a collaborative element to the conversations. Although the patient as hearer is found to take a passive role in following and reacting to the counsellor's responsive or narrative cycles, there is still evidence of collaboration in the way patients respond and participate in the interaction, albeit on a minimal level.

Generic features throughout the development further limit the patient in that when an opportunity to take the floor is provided (which does not occur often in this conversation type), the packaging of the preceding turn which hands over the speaking turn generally offers the next speaker a speech act that is required to be short, such as a yes or a no answer. Due to this imbalance in talking turns during which counsellors mostly convey information, an

³¹ *Nina mo* and *Minnie mo* indicate Nina and Minnie's mothers respectively as side-participants in the conversation.

especially prevalent phenomenon found throughout these conversations is that of hearer signals. This remarkable feature of pre-HIV test counselling sessions merits an in-depth investigation, which is provided in the following chapter.

Chapter Six

ANALYSIS OF HEARER SIGNALS

6.1 INTRODUCTION

In the previous chapter the generic features of pre-test VCT counselling sessions as a conversation type within the genre of medical discourse were investigated, identified and characterised. A crucial feature found throughout the three interrelated levels on which the analysis focused is the fact that one participant – with institutional power – exerts a great degree of control while the other – who is in a vulnerable position – yields without much conversational participation. An expectation of patients to take the main role of listening and absorbing is apparent and although they do get opportunities to participate by providing background and answering questions, they are rarely given the opportunity to relay what they know.

The main aims of pre-HIV test counselling are (i) to inform the patient regarding various HIV-related topics and (ii) to ensure that the patient fully understands this information in order to make a decision in giving consent (cf. section 2.4.3.1). The structure of institutional interaction like this is found to be created according to the nature and goals of the institutional context (cf. section 3.3.5.1). As a result, the counsellor controls and manages the structure and development of the conversation in light of achieving the institutional tasks inherent to the conversation type. Chapter five provides evidence for the way in which this rigid structure then restricts patients in terms of communicative contribution. In this way, counsellors are generally found to achieve the first aim, but often fall short in terms of the second aim, namely of soliciting and assessing the extent of patients' knowledge on the subjects covered in talk.

It is generally understood that in any conversation the same person is at certain times the speaker and at other times the hearer. The conversation type known as pre-test VCT counselling, however, reveals an imbalance in the distribution of speaker and hearer roles. The larger part of the conversation is made up of long monologic information-giving sequences by the counsellor in a speaker role, during which the patient as hearer typically contributes by producing meaningful signals directed towards the speaker. Although hearer

signals are provided by both participants throughout the conversation, it is found that the patients in these conversations play an overwhelmingly strong listener role, which is why this chapter will only take into account the hearer signals provided by patients.

In following up on the previous section, this chapter aims (i) to identify the forms of hearer signs and signals that occur in pre-HIV test counselling sessions, (ii) to interpret these hearer signals, and (iii) to select the most widely used forms in order to analyse their use in signalling various messages of the patient, their contribution to the conversation and the way in which they are interpreted by various participants.

6.2 CONVERSATION SUBTYPES

As previously mentioned (cf. section 4.3.2) four conversation subtypes were found in the data: in clinic A there were mothers bringing their infants (AMI) for testing and accompanied pre-/adolescent females (AAA); in clinic B there were medical male circumcision volunteers (BMMC) as well as male and female patients referred by other HCPs and general volunteers (BRF & BRM). This then identified five types of hearers within the data: (i) mothers testing their infants, (ii) pre-/adolescent females and (iii) their accompanying mothers as (un)addressed side-participants, (iv) medical male circumcision volunteers and (v) referred or general patients.

Where clinic A has one counsellor who administered the six consultations, the eight sessions at clinic B were distributed between two counsellors. This is not a comparative study, thus the data of the two clinics are used additively to establish what kinds of orderliness can be found within the format of certain types of conversations. The various styles of the different clinics, counsellors and types of patients (“hearers” for current purposes) will be analysed in association with each other. In the event of similar phenomena presenting throughout different clinics, with different counsellors, one can assume that the features are generic to a broader type of conversation that has developed its own set of rules. This warrants an investigation of the ways in which specific, commonly occurring features such as language signals are used and interpreted.

6.3 FUNCTIONS OF HEARER SIGNALS

In general talk-in-interaction, hearer signals are found to take the form of continuers, assessments, acknowledgers, receipts, personal expression as well as signals that aim to influence the speaker (cf. section 3.5.4). Examples of each of these functions of hearer signals are present in the data, together with some additional functions specific to this discourse type. It should be made clear, however, that these hearer signals are often ambiguous in that a single function cannot necessarily be identified and that the intention behind its production is mostly intuitively, pragmatically and contextually determined. For this reason, all the functions are completely dependent on linguistic and situational context. Apart from the functions mentioned above, hearer signals in this context are found to be produced as some form of confirmation (6.3.5), to express a kind of inner state (6.3.6), to show recognition (6.3.7) or agreement (6.3.8), and to emphasise words or phrases uttered by the speaker (6.3.11). Attention is further given to the way in which the speaker can influence a hearer to produce a signal (cf. 3.5.5.3) in providing prompts during speech (6.3.4). Below the complete list of hearer signals together with illustrative examples from the data will be given.

6.3.1 Following

As stated above, more than one function can be performed in the production of a hearer signal. It is safe to assume that if any of the functions is assigned to a hearer signal, that the hearer as the producer of the signal is always also – at a basic level – signalling that s/he is following the ongoing speech. A hearer cannot confirm, agree to or acknowledge information without revealing that s/he is concurrently following the speaker's utterances with comprehension, which is what I will refer to as 'true following'. In contrast, signals that reveal 'false following' are those produced by hearers in order to make themselves come across as if they are following and does not necessarily mean that they are in fact following with comprehension. This function aims to accommodate the likely possibility for hearers to automatically produce signals without understanding or following (Bublitz, 1988:172), as hearer signals "at best *claim* attention and/or understanding, rather than *showing* it or *evidencing* it" (Schegloff 1982:78, italics in original).

Parallel to continuers, this category is different to most others in the sense that it is applied on a structural level and carries no stable underlying semantic value, as the aim of these signals is rather to indicate that the speaker has the hearer's attention in the hearer's (i)

acknowledgement of ongoing incomplete extended speech, (ii) encouragement to continue and finish the discourse unit, and (iii) declaration that s/he will not be making claims to the opportunity of the current potential speech turn (Schegloff, 1982; Gardner, 2001:14). Unlike the other functions, hearer signals in this category do not aim to comment on the content of the speaker's utterance, which renders the sincerity of the understanding behind the signal difficult to judge.

As many in this category, the verbal and nonverbal hearer signals in intervals 120 and 121 in example a) below can belong to more than one category.

a) Leon (BRM2) with Charles

	118 [02:38.6]	119 [02:39.3]	120 [02:39.9]	121 [02:40.6]	122 [02:41.5]
C[v]	Jy't gesien net 'ou	die dametjie	gee jou 'n vorm	om te teken	waa' jy
C[FP]	<i>Jy't gesien netnou</i>				<i>waar jy toestemming gee</i>
C[ENG]	You saw just now	the girl	gave you a form	to sign	where you give consent
P[v]	sy'			Ja daarsy'	
P[FP]				<i>Daar's hy</i>	
P[ENG]	there'			Yes, that's right'	
P[NV]			<i>nodding'</i>		

The nodding (120) is produced directly after an important content word, “girl”. In the preceding utterance, the counsellor informs Leon that he, too, has a form. By introducing his consent form, the counsellor provides a context in which the phrase, “the girl” (referring to the researcher) fits naturally (as Leon's only interaction with “the girl” was structured around a consent form), making the consequent nodding an appropriate gesture revealing that Leon is following with comprehension. During the nodding, the counsellor then provides the contextually appropriate elaboration, after which Leon provides another acknowledging signal to indicate that he is successfully following in mutual alignment: “Yes, there it is/that's right”.

The extract above provides an example of clear understanding and following shown by a patient by means of a hearer signal. It contains information relating to the researcher and the research project, which demonstrates how a lot of talk during these sessions is of an administrative nature. While this particular extract does not contain content typically found in VCT sessions per sé, it represents the type of talk that is inherent to these conversations. The bulk of the examples that follow will focus on conversation topics typically found during these types of conversations.

Although it is impossible in all circumstances to infer fully what another's state of mind is, example b) overleaf shows a hearer signal that appears to be placed unnaturally, in which case false following can be argued.

b) Maggie (BRF2) with Charles

	100 [04:41.0]	101 [04:41.7]	102 [04:43.7]	103 [04:44.6]
C[v]	ma' •	((unint., 0,3s)) Daar's 'n verskil tussen • •	HIV •	en VIGS, nè?
C[FP]	<i>maar</i>			
C[ENG]	but •	((unint., 0,3s)) There's a difference between • •	HIV •	and AIDS, right?
C[SUP]			HIV: EP	
P[NV]	<i>nod</i> ´		<i>nod</i> ´	

The nod in interval 102 coincides with the main content of the information given by the speaker. The speech preceding this excerpt does not create a context in which it would be possible to anticipate the information that is to follow interval 101. A more natural placement for the nod would have been during or after interval 103 in (and after) which the key information is given. Although the unnatural pause before this information could have prompted this reaction in that the hearer might have produced it to encourage the speaker to continue, the blank facial expression and small size of the nod do not suggest that it carries this type of intention.

6.3.2 Understanding

Much the same as with following, the function of a hearer signal produced to show understanding will overlap with other functions. Therefore, it is implied that if a hearer signal is for instance categorised as agreeing with or confirming information uttered by the speaker, its function is also to show understanding. Similar to the previous category, judging sincerity is difficult in this case, as these hearer signals do not always take the form of “I understand, yes.” By sequentially analysing the placement of the hearer signal, referring to the ongoing discourse’s degree of success as a whole, as well as taking the hearer’s facial expression, gaze and body language into account, a fair judgement can be made in most cases. What is said by the hearer once s/he takes the floor during her/his next speaking turn, for example, can also reveal her/his level of understanding. Body language and facial expression can also be an indication of an individual’s state of mind and is taken into account throughout.

Hearer signals in the form of words or phrases uttered in synchronisation with a similar utterance to the speaker can be assumed to show understanding.

c) *Minnie (AAA2) with Mary*

	68 [02:20.9]	69 [02:25.6]
C[v]	••• 'n Swanger mammie kan die virus kry met/ •• uh uh aan haar kind oorgee •• met	geboortes.
C[ENG]	••• A pregnant mommy can contract the virus with/ •• uh uh give it to her child •• at	birth.
PM[v]		• Geboorte
PM[ENG]		• Birth
PM[SUP]		soft
PM[NV]		<i>slight nod</i>

In some cases, the hearer offers a sentence ending or repeats words uttered by the speaker without it being an attempt to take the floor, judging by the way it is treated by participants. This is taken to be a clear indication of understanding which is especially reinforced by body language. In example c) above, Minnie's mother utters the same word as the counsellor just after the speaker starts to utter it. It does not aim to take the floor, as it is uttered softly and is not responded to by other participants. The accompanying body language in the form of a nonverbal signal, the head nod, also complements the intention behind its production. This clearly shows comprehension since the hearer has to understand unfolding talk in order to anticipate and produce an overlapping hearer signal like this.

In order to illustrate how some hearer signals in the form of phrases are judged to be hearer signals instead of the hearer aiming to take the floor, an example of the latter is given in excerpt d) below.

d) *Hans (BMMC1) with Mary*

	149 [04:24.3]	150 [04:27.3]	151 [04:28.1]	152 [04:28.7]
C[v]	• ons moet mos eers kyk of • hoe ver	is...	Ja, hoe	hoog is die... •
C[ENG]	• we must first see • how far	is...	Yes, hoow	high is the... •
P[v]		Hoe hoe hoog is die...		• Ek sien,
P[ENG]		How how high is the...		• I see, okay
P[SUP]				softly
P[NV]		<i>nodding</i>		

The counsellor is busy talking about the importance of establishing the CD4 count in this excerpt. The fact that she trails off mid-utterance at the end of interval 149 might prompt Hans to offer an appropriate sentence ending. While this is an example of him showing his understanding by aiding the counsellor in providing a contribution, it is important not to mistake this utterance for a hearer signal as it directly contributes to the unfolding of the conversation. The counsellor reacts to this phrase by confirming that it is in fact an

appropriate contribution within context “Yes”, as well as repeating and then elaborating on Hans’ utterance.

6.3.3 Acknowledgement

There are times when hearer signals merely acknowledge speech production (cf. section 3.5.4.2). A general example would be the acknowledgement of an informative statement uttered by the speaker, whether it is HIV related or describes the prospective procedures. Other pieces of speech that seem to be acknowledged include greetings, advice, suggestions, apologies or reassurance offered by the counsellor. Hearers might even merely acknowledge the fact that an utterance has been directed at them, whether or not they understand its content.

While each conversation contains narrative cycles in the form of information-giving utterances on HIV-related topics, general information conveyed in talk differs from context to context. During conversations with mother-and-infant combinations general talk include topics like the baby’s health, weight and eating habits. In excerpt e) below, the subject is the baby’s weight.

e) Louise (AMI2) with Gretha

	31 [01:07.9]	32 [01:09.5]	33 [01:10.3]	34 [01:12.4]
C[v]	Dis dinge wat maak 'at die kinders nie,		• • optel en hulle kosse eet nie.	• •
C[FP]	<i>Dis dinge wat maak dat die kinders nie...</i>			
C[ENG]	Those are things that cause the children not to,		• • pick up and eat their food.	• •
C[SUP]	rising intonation at end			
P[v]		• • Optel 'ie'		
P[ENG]		• • gain weight'		
P[NV]		<i>nod'</i>		<i>nod'</i>

The same as in many cases, there might be other reasons behind the hearer signals (32) such as the rising intonation and pause provided by the speaker (31-32) which could serve as a prompt to the hearer. Additionally, by offering an ending to the sentence, the hearer shows understanding of the conversation, as well as true following throughout.

Informative topics covered during the sessions in which men are tested before undergoing voluntary MMC include among others, the fact that these patients first need to be tested for HIV, as in the case in excerpt f) overleaf. Throughout the counsellor’s speech, Pieter provides hearer signals (23-25 & 26-31) that seem to acknowledge the information provided.

f) *Pieter (BMMC2) with Mary*

	22 [00:42.1]				23 [00:47.5]	24 [00:48.0]	25 [00:48.4]
C [v]	•• Jaa ah • ons wil ma' net ee'ss • weet of • wat is jou • MIV				status.		Voor/
C [FP]	<i>Jaa ah, ons wil maar net eerss weet of wat is jou MIV</i>				<i>status.</i>		
C [ENG]	•• Yes ah • we just want to firsst • know • what is your • HIV				status.		Before/
P [v]						Okay'	
P [ENG]						Okay'	
P [NV]					<i>nodding' (23-25)</i>		
	26 [00:48.9]	27 [00:49.9]	28 [00:50.4]	29 [00:51.0]	30 [00:51.6]	31 [00:52.0]	
C [v]	Voor jy ga' gaan	vir 'ie	•• vir 'ie	MMC	•	sien jy?	
C [FP]	<i>Voor jy gaan gaan</i>	<i>vir die</i>	<i>vir die</i>				
C [ENG]	Before you go	for the	•• for the	MMC	•	do you see?	
C [SUP]				MMC: EP			
P [v]	•• Voor die...		• -snyding		Hm'		
P [ENG]	•• Before the ...		• -cision				
P [NV]		<i>Nodding throughout' (26-31)</i>					

Another common utterance that generally receives hearer signals from patients occurs when the counsellors orientate the patients by explaining the procedure that is to follow, what can be expected, etc. This type of information often attracts hearer signals of acknowledgement, as can be seen in interval 201, below.

g) *Letitia (BRF3): Interval 201*

	199 [05:53.9]	200 [05:54.6]		
C[v]	tig, nè?	• • • Okay • • so • • ons sal mar net ee's jou vormpie teken		
C[FP]		<i>Okay, so ons sal maar net eers jou vormpie teken,</i>		
C[ENG]	ty, right?	• • • Okay • • so • • we will first just sign your vorm,		
P[v]	Hmm´			
P[SUP]	affirmative			
	201 [05:59.0]	202 [05:59.8]	203 [06:00.2]	204 [06:00.9]
C[v]	• • dan is	onss,		klaa'.
C[FP]				<i>klaar.</i>
C[ENG]	• • then we	arre,		done.
P[v]	Hmm´		• Hmm´	

6.3.4 Reaction to prompt

Literature on the influence of the speaker on the production of hearer signs is provided in Chapter three (section 3.5.5.3). Closer investigation of the data reveals that speakers often employ techniques that serve as motivation behind the production of hearer signals. Firstly, prompts in the form of words like “nè” and “mos.” “Nè” can be translated to “isn’t it?” / “not so?” / “yes?” / “right?”, is similar to the verbal tic “y’know?” and is normally uttered at the end of a sentence, but can be found earlier throughout utterances as well. Although it is sometimes uttered rhetorically or habitually, its presence in a sentence is found to compel a hearer to react with a signal. Quite along the same lines, “mos,” an adverb of modality, can

roughly be translated to “as you know”, “indeed” or “of course”. By using this term, the speaker assumes that what is being said is shared knowledge which could pressurise the hearer to substantiate this assumption. In table 6.1 below, a total number of occurrences of both these prompting words is given together with the number of times that each hearer reacts to them by providing a verbal or nonverbal hearer signal. The data here is organised according to the quantitative statistical measure of how many hearer responses were recorded.

Table 6.1: Hearers’ reaction to lexical prompts “*nè*” and “*mos*” uttered by the speaker

	<i>Nè</i> Total	Total reacted to	Reaction %	<i>Mos</i> Total	Total reacted to	Reaction %
(AMI1) Alison	7	7	100%	6	6	100%
(AMI4) Mandy	6	6	100%	1	1	100%
(BRM2) Leon	21	21	100%	8	8	100%
(BRF3) Letitia	17	16	94%	5	5	100%
(AMI3) Chané	14	13	93%	3	3	100%
(BMMC1) Hans	10	9	90%	7	7	100%
(BMMC3) Henk	28	25	89%	3	3	100%
(BRM1) Pedro	21	10	48%	3	3	100%
(BRF1) Jo-Anne	48	37	77%	7	6	86%
(BMMC2) Pieter	17	14	82%	6	5	83%
(AMI2) Louise	8	4	50%	3	2	67%
(BRF2) Maggie	15	14	93%	0	0	0%
(AAA1) Nina	12	9	75%	1	0	0%
(AAA2) Minnie	8	6	75%	0	0	0%

Explanations can be provided for the majority of patients in which the rates of reactions to these two prompts are lower. The two participants of schoolgoing age, Nina and Minnie, for example, did not react to prompts during times in which eye contact was not maintained. Sometimes the counsellor was not facing the patient as prompts were uttered, at other times the patient avoided eye contact with the counsellor. For both these patients, 100% of the prompts not reacted to occur during these circumstances. In the case of a low reaction rate among the mothers with infants, Louise found herself distracted throughout the session. During the time she tended to her restless infant, she reacted less to these prompts. As the exception, Pedro tended to react less on “*nè*” specifically despite not being distracted and maintaining eye contact.

The data further show that changes in intonation as well as pause placement within utterances tend to prompt a reaction from the listener. The rising and falling intonation of an “either/or”

phrase, together with specific pauses, for example, might affect the hearer, as the examples below illustrate. The same goes for the uttering of lists, which also has specific tonal features and pauses throughout, as well as “If ... then ...” sentences in which hearers often produce a signal in the natural pause before the second clause introduced by “then”. Other phenomena that might have the same effect could be when the speaker directly addresses the listener, emphasises specific words, or trails off or abandons sentences.

Excerpt h) below provides an example where the placement of “nè” at the end of a phrase within a sentence (106) is responded to by a verbal and nonverbal hearer signal (107), whereas i) provides an unnaturally placed reaction (75) produced after “mos” is uttered by the counsellor (74).

h) Leon (BRM2) with Charles

	104 [02:24.2]	105 [02:24.4]	106 [02:24.8]	107 [02:26.7]
C[v]		Ek is 'ie	berader. ˘So alles wat ons doen, nè?	
C[FP]		<i>Ek is die</i>		
C[ENG]		I am the	counsellor. ˘So everything we do, right?	
P[v]	Daar-	sy˘		'aarsy
P[FP]				<i>Daar's hy</i>
P[ENG]	There you	go˘		Right, Si-
P[NV]	<i>nod˘</i>			<i>nod˘</i>

i) Pieter (BMMC2) with Mary

	74 [01:55.6]	75 [01:57.8]
C[v]	•• Ma' die mense wat MIV VIGS hulle kry mos 'ie	behandeling om de' die
C[FP]	<i>Maar die mense wat MIV VIGS hulle kry mos die</i>	<i>behandeling om deur die</i>
C[ENG]	•• But the people with HIV AIDS they get the	treatment to move through
P[NV]		<i>nodding˘</i>

One counsellor uses changes in intonation, specifically rising and falling intonation techniques together with providing a prompting pause similar to the way a teacher would do in a classroom to elicit student participation, prompting the hearer to finish the sentence or provide some kind of feedback as can be seen in intervals 204 and 206 in excerpt j) overleaf.

j) Alison (AMII) with Gretha

	202 [05:07.6]	203 [05:11.0]	204 [05:11.6]	205 [05:12.2]	206 [05:12.6]
C[v]	possibilities kan wees dat hy negatief kan wees,	• possibil-	ty kan wees,	dat hy	• • positief
C[FP]	<i>possibilities kan wees dat hy negatief kan wees,</i>				
C[ENG]	possibilities can be that he can be negative,	• possibil-	ty can be,	that he's	• • positive.
C[SUP]	rising intonation at end			rising intonation	falling intonation
P[v]			Positi...		• • Positive.
P[ENG]			Positi...		
P[SUP]			soft		
P[NV]					<i>nodding</i>

In some cases, the way in which counsellors address hearers might influence the production of a hearer signal. Utterances that start with words of demand, like “Remember”, or “Look here” often result in the production of a hearer signal. The same effect is found when a counsellor directly addresses the patient, of which k) below is an example. Here, the counsellor addresses Leon directly by beginning his sentence with both the prompt word, “mos” and a direct address, “Like you said ...” (274), after which Leon provides a nod (275).

k) Leon (BRM2) with Charles

	273 [05:14.7]	274 [05:16.3]	275 [05:17.3]	276 [05:17.5]
C[v]	raak, nè? • • Of dan nou	mos so soos jy sê	as jy	nie ‘n kondoom gebruik’ie,
C[FP]		<i>mos so soos jy sê</i>	<i>as jy</i>	<i>nie ‘n kondoom gebruik nie,</i>
C[ENG]	right? • • Or then	like you said	if you	don’t use a condom
P[v]	Kan siek raak, • • ja ja			
P[ENG]	Can get sick, yes yes			
P[NV]	<i>nodding</i>		<i>nod</i>	

6.3.5 Confirmation

Occasionally hearer signals are used as a sort of announcement to confirm that information given by the speaker is correct. This can occur when the speaker reads information about the hearer from her/his file, repeats information provided by the patient a moment ago, or makes a statement that might be perceived as a question, all to which hearers react by confirming through the back channel.

In these instances, hearers simply confirm that information given by the speaker is correct or in the alternative, confirms that it is incorrect, as can be seen in l). Confirmation of negative statements in the form of the shaking of the head are also found, of which an example is provided in m) overleaf. There are also many examples where the counsellor asks the patient a question and then repeats the answer provided, to which the hearer then signals the confirmation of correct information (n).

l) Jo-Anne (BRF1) with Mary

	..	308 [09:34.9]	309 [09:35.9]
C[v]	So jy is nou •• heeltemal ui/ uit op 'ie voorbehoed.		Okay.
C[FP]	<i>nou, heeltemal ui/ uit op die voorbehoed.</i>		
C[ENG]	So you are now •• completely o/ off of birth controll.		
P[NV]		<i>nodding</i>	

In the example above, the counsellor's utterance in 307 is a statement. If it were to be a question, the nodding in 308 would have been a second pair part provided after a question as part of an adjacency pair. The hearer is not obliged to produce the signal in 308 and the following "Okay" (309) is uttered in a way that indicates it is produced as a discourse marker rather than a response to the nodding. This is apparent in the intonation thereof as it is uttered in a way that creates an expectation of following talk.

m) Mandy (AMI4) with Gretha

	55 [01:27.1]	56 [01:30.1]	57 [01:30.7]	58 [01:31.3]
C[v]	•• Julle sit 'ie buh uh • stokkielekkers en	chips uh...	• O's/ •	dis wat die kinnars se eetlus
C[FP]	<i>Julle sit nie buh uh, stokkielekkers en</i>		<i>Ons/</i>	<i>dis wat die kinders se eetlus verdamp,</i>
C[ENG]	•• You don't put buh uh • lollipops and	chips uh...	• We/ •	that's what dulls the children's appetites,
P[v]		Hrñhm.		
P[SUP]		negative		
P[NV]		<i>shaking head</i>		<i>nodding</i>

The use of "You" in the counsellor's statement (55) is not intended to address the hearer as it is in the plural form. In this way, the counsellor is referring to the generic "you" as she suggests that people should generally refrain from giving children lollipops and chips. By providing a verbal and nonverbal hearer signal (56 & 58), the hearer can be seen to confirm that she too generally does not give her child lollipops and chips. She is furthermore shaking her head since she is confirming a negative statement from the speaker.

n) Nina (AAA1) with Gretha

	219 [05:59.5]	220 [06:01.2]	221 [06:01.3]	222 [06:01.8]	223 [06:03.1]
C[v]	•• Hoe oud is jy, • Ni-	na?		••• Sewentien.	
C[ENG]	•• How old are you, • Ni-	na?		••• Seventeen.	
P[v]		Se-	wentien.		
P[ENG]		se-	venteen.		
P[NV]					<i>nodding</i>

In this example, the counsellor repeats the patient's answer with a falling intonation as if repeating it to herself while writing this information down. Regardless, the hearer nods in confirmation after she hears the speaker utter it.

6.3.6 Personal Expression

Similar to a confirmation of information as illustrated above, hearer signals are found to be produced to indicate a hearer's inner state. In these examples the patient can use a hearer signal during a speaker's utterance to express an inner state such as her/his willingness to do a specific task or readiness to receive speech.

6.3.6.1 Willingness to oblige

Hearer responses in these cases can also be seen to take the form of a second pair part responding to an initiated adjacency pair (request and compliance), in which case politeness dictates that the receiver of a request for action from another interactant provides some response before or while carrying out the requested action. With that being said, it is argued that these signals are multifunctional in that they can also be interpreted as a hearer signal with an isolatable function, the expression of an inner state.

In some cases throughout the counselling session, the counsellor utters simple requests at the beginning of a sentence to the patient of which "listen here" and "look here" are prevalent examples. These are not direct requests as it is not intended as a deictic reference of something in their mutual surroundings. It is furthermore usually followed closely by the next utterance and is in this way not intended as a first pair part as no pause during which the floor is handed to the addressee to reply is provided thereafter. In cases where these kinds of requests are followed by some kind of hearer signal, it is argued that these signals are used to convey that the patient is in fact ready and willing to listen to the following utterance(s). In a way, thus, the hearer is informing the speaker of her/his inner state of willingness to oblige to

an uttered request, whether the request is rhetorical “Look here ...” or literal “Come sign here”.

o) Leon (BRM2) with Charles

	334 [06:24.8]	335 [06:28.6]
C[v]	Haa'sy. ••• Leon sê vi' my voor ek nou • gou voortgaan met die toetsie,	•• is
C[FP]	<i>Daar's hy. Leon, sê vir my voor ek nou, gou voortgaan met die toetsie</i>	
C[ENG]	There you go. ••• Leon tell me before I continue • now with the test,	•• is
C[SUP]	rising intonation at end	
P[v]		((unint., 0,4))
P[NV]		<i>nod</i>

The counsellor begins his utterance in the example above by addressing the patient followed by an instruction “tell me” (334) to which he reacts by producing a short unintelligible utterance paired with a nod at the next juncture. The fact that this utterance is mumbled can mean that Leon is not intending to make a contribution to the conversation as the speaker, but rather confirming through the back channel that he is in fact willing to tell the counsellor whatever it is that he wants to know. Although this speech act is not a signal provided out of obligation when considered in this light, it can also be produced as a reaction to the direct way in which the counsellor addresses him by saying his name (334), as well as this utterance’s rising intonation.

6.3.6.2 Display of reciprocity (Heath 1986)

As elaborated on in section 3.5.4.5, Heath (1986) argues that specific nonverbal hearer signals, specifically the shifting of the gaze toward the HCP can act as a display of reciprocity. I aim to argue that the same can be done with a head nod. In the data, head nods can be seen to act as a movement to signal a patient’s (inner state of) readiness to receive speech. In example p) below, the patient gives a firm nod in the direction of the counsellor before the onset of the counselling session which overlaps no speech and precedes any turn allocation. This happens as the counsellor settles before introducing herself.

p) Pieter (BMMC2) with Mary

	1 [00:02.6]	2 [00:02.8]	3 [00:03.6]	4 [00:05.9]	5 [00:06.2]
C[v]		Môre.	••• Okay •• my naam is Mary.		Ek is die beraders.
C[ENG]		Morning.	••• Okay •• my name is Mary.		I am the counsellors.
P[v]		•• Môre.			
P[ENG]		•• Morning.			
P[NV]	<i>firm nod</i>			<i>nodding</i>	

6.3.7 Recognition

In some cases, the speaker refers back to a previous session with the same patient, in which hearer signals of recognition can be found. This does not necessarily only refer to specific things that the two interactants share in the past, but can also simply be a word or term that the hearer apparently recognises and accordingly reacts to. Example q) below is an example where the recognition is apparent. The counsellor is referring to medication that she gave the patient at a previous occasion and even guides the patient's in articulating that she "just want[s] to quickly take [her] back." The nodding as well as the overlapping elaboration of understanding, "Those first ones, hm" (145 & 146), show that she knows what the speaker is referring to, and recognises the content of her speech.

q) *Alison (AM11) with Gretha*

	143 [03:19.6]	144 [03:22.0]	145 [03:22.3]	146 [03:22.9]
C[v]	vi' jou die Naveropine stropie gegee t' et e' wil jou	net gou	terugneem.	
C[FP]	vir jou die Naveropine stropie gegee het ek wil jou	net gou		
C[ENG]	gave you the Naveropine syrup I just want to	quickly take you	back.	
P[v]			Daai eers-	tes, hm.
P[ENG]			Those firs-	t ones, hm.
P[SUP]				affirmative
P[NV]		<i>nodding</i>		

6.3.8 Agreement

As the category suggests, these hearer signals are employed to show agreement with what the speaker uttered and can be substituted with a verbal equivalent such as "Yes, I agree," or even "No, I agree with your negative statement." In this case, one might also expect to see hearer signals in the form of objections. Although this is typical in day-to-day speech, it does not occur in the collected data as (i) the aim of the session is the provision and interpretation of biomedical information, and (ii) the context in which it takes place does not generally provide one with hearers who possess expert knowledge or a specific opinion regarding the subject matter. Again, it is possible to have overlapping functions, or, in some cases it could be equally judged as being either one category or the other. Example r) overleaf, for example, could just as much be an acknowledgement of a statement as it could be an agreement with it.

r) Louise (AMI2) with Gretha

	26 [00:55.8]	27 [00:59.6]
C[v]	• • Okay • dis baie belangrik, nè dat ons hulle die vyf maaltye	gee 'at
C[FP]	<i>Okay, dis baie belangrik, nè dat ons hulle die vyf maaltye</i>	<i>gee dat ons</i>
C[ENG]	• • Okay • it's very important, right that we give them the five meals	so that we
P[v]		
P[NV]		<i>nodding</i>

Although it might be argued that the speaker could have prompted the nodding below by uttering the word, “nè”, the fact that there could be other reasons behind the nodding in interval 27 is irrefutable. While this could also be a simple acknowledgement of information, the case that it is agreement seems more feasible. The speaker is busy giving a mother of a baby information about feeding and is giving information that is clearly known to the hearer, as this is not her first visit and these subjects have been dealt with in previous sessions during and after her pregnancy.

6.3.9 Assessment

Assessments are concerned with judging the content of an utterance. Gardner (2001:14) provides the term “newsmakers” for these signals that judge information to be interesting. Since these signals are based on content, rather than structure, their placement within a speaker’s turn will be different in comparison to hearer signals that reveal understanding and following in the form of continuers, for example. Since these signals are concerned with a specific piece of information, rather than the structural flow thereof, it will most probably overlap or follow the speech that it assesses.

Judging by Hans’ utterance, “Oh” (137), as well as its placement in s) overleaf, it can be assumed that he is indicating that he finds this information to be new and newsworthy.

s) *Hans (BMMCI) with Mary*

	136 [03:53.7]	
C[v]	•• Mar jy moet onthou •• ons trek die CD vier telling • as net die toetse wys dat jy	
C[FP]	<i>Maar</i>	
C[ENG]	•• But you must remember •• we draw the CD four count • if the tests only show you	
	.. 137 [03:59.1]	
C[v]	het MIV VIGS.	┘As jy het 'ie,
C[FP]		<i>As jy het nie,</i>
C[ENG]	have HIV AIDS.	┘If you don't have it,
P[v]		• Öh´
P[ENG]		• Öh´

6.3.10 Interest

One hearer signal that seems to convey interest or inquisition occurs in the session of the only patient who asks a question. Throughout the data, hearers generally do not seem interested to receive or interpret information directed at them. This could be due to emotional stress in the anticipation of taking an HIV test which could influence a patient's general attitude in these sessions and it is safe to assume that this might be a reason for their general lack of enthusiasm.

In example t) below, as the speaker starts elaborating on her explanation of blood cells, she provides a metaphor. After she starts introducing the metaphor to come: "It works like ... like a" (118), in the pause that follows, the hearer lifts his chin as if to nod, but brings this movement to a standstill, suspending the nod by keeping his face tilted upward and maintaining focussed eye contact. As soon as the key word of the metaphor is uttered in intervals 119 and 120, the patient lifts his chin more as the start of his nodding signal of understanding.

t) *Hans (BMMCI) with Mary*

116 [03:10.9]		117 [03:13.1]	118 [03:13.5]
C[v]	Die bloedselletjies, dit beskerm ons liggaam.	Dit werk soos uuhm • soos uh • soos 'n sol/ soos 'n	
C[ENG]	The blood cells, it protects out body.	It works like uuhm • like uh • like a sol/ like a	
P[NV]		<i>nod´</i>	
119 [03:16.6]		120 [03:17.6]	121 [03:18.2]
C[v]	• ssoldaatjie by	ons liggaam,	nè?
C[ENG]	• ssoldier in	our body,	right?
P[v]			Okay
P[NV]	<i>lifts chin, tilts head upward</i>	<i>Nodding</i>	

6.3.11 Emphasis

Lastly, hearer signals that seem to function to emphasise what the speaker has said by means of strongly acknowledging specific pieces of utterances are identified. This only occurs in the sessions where two hearers are present. Within these counselling sessions, the parent or guardian often takes conversational lead on behalf of the children whose discomfort and anxiety is apparent. During the information-giving sequences directed mostly to the patient, the third party sometimes uses hearer signals to emphasise the importance of specific utterances by complementing the counsellor's speech in a way that is different to other functions of hearer signals as it is aimed at another hearer in context, rather than the speaker.

In excerpt u) below, the counsellor is explaining the importance of avoiding blood to blood contact when another pupil has been hurt on the playground. The patient's mother repeats the important phrase, "kaal hanne," overlapping the speaker's utterance while nodding and shifting her gaze and body posture from the counsellor to her daughter. By doing this, she might be emphasising this point in order to indicate its importance to her daughter.

u) *Minnie (AAA2) with Gretha*

	113 [03:46.5]	114 [03:48.8]	115 [03:49.2]
C[v]	• • Ma' moenie • met jou kaal	hanne	• an v/ 'n volgende persoon se bloed vat'ie
C[FP]	<i>Maar moenie met jou kaal</i>	<i>hande</i>	<i>aan v/ 'n volgende persoon se bloed vat nie</i>
C[ENG]	• • But don't • don't with your bare	hands	• touch t/ another person's blood.
P[FP]			
PM[v]		Kaal hanne'	
PM[FP]		<i>Kaal hande</i>	
PM[ENG]		Bare hands'	
PM[NV]		<i>nodding'</i>	

Important pieces of information can also be emphasised by providing a strong affirmative non-speech hearer signal, such as the "Hm" in interval 90, overleaf. The counsellor is explaining that while the contraceptive implant will prevent pregnancy, it will not prevent a person from contracting an STI. The hearer signal that emphasises this point is found directly after the utterance is completed (90) and can assume to be intended to serve as an attempt to make another hearer attend more carefully to what is being said or what has just been said.

v) *Nina (AAA1) with Gretha*

	87 [02:11.3]		
C[v]	••• Dit gan vi' jou keer dat jy nie moet swanger raak, ma' dit gan nie keer • dat jy		
C[FP]	<i>Dit gaan vir jou keer dat jy nie moet swanger raak, maar dit gaan nie keer dat jy</i>		
C[ENG]	••• It will prevent you from getting pregnant, but it will not prevent • that you get		
	88 [02:15.6]	89 [02:15.8]	90 [02:16.3]
C[v]	dit	kry nie.	
C[ENG]	it		
PM[v]		Hm̃	
PM[ENG]		Hm̃	
PM[SUP]		Affirmative	

6.4 OVERVIEW OF FUNCTIONS OF HEARER SIGNALS ACCORDING TO SESSION TYPE

The hearer signals found in the data were divided into a verbal and nonverbal category. The verbal hearer signals were then subdivided into (i) non-speech verbal items such as “hm” and “uh”, (ii) one-word speech utterances (as well as repetitions thereof) like “yes”, “no” and variations of “okay”, as well as (iii) phrases in the form of continuers such as “I see” or “that’s right” and content specific phrases in the form of simultaneous sentence endings or repetitions of the last word of the speaker. Also included in these content specific phrases are unintelligible utterances that are judged to be longer than one-word utterances and are hearer signals as it is usually mumbled by the patient and a clear attempt not to take the floor. Nonverbal hearer signals then include head nods and head shakes.

Before presenting a summative overview of the most used hearer signals as well as their functions throughout these conversations, the average number of hearer signals produced by each group is given in table 6.2 overleaf. Since the number of patients in each group differs (AMI: four, AAA: two, AAAM: two, BMCM: three and BR: five), the total of hearer signals produced by a group (e.g. 200 for AMI) was divided by the number of people in the group to get the average number of hearer signals provided by each participant (i.e. 50 per person in AMI). In order to further compare the numbers fairly, the average time for each conversation is given (AMI: 5:51 minutes) together with its corresponding number of seconds (AMI: 351 seconds) in order to calculate the average number of hearer signals produced each minute (AMI: 14.2) and the number of seconds after which a patient in each session on average produces a hearer signal ($351/50 = 7$).

Table 6.2: Hearer signals production average

	Average time: minutes	Average time: seconds	Total hearer signals	Average number of hearer signals per person	Average number of hearer signals per minute	Average number of seconds per hearer signal per person
AMI ³²	5:51	351	200	50	14.2	7
AAA	6:58	418	14	7	1.7	59.7
AAAM	6:58	418	35	17.5	4.2	23.9
BMMC	7:31	451	198	66	14.6	6.8
BR	9:11	551	336	67.2	12.2	8.2

According to these calculations, medical male circumcision volunteers most frequently produce hearer signals (every 6.8 seconds) followed by mothers testing their infants (every 7 seconds), referred patients (every 8.2 seconds), mothers accompanying their pre-/adolescent daughters (every 23.9 seconds) and pre-/adolescent females (every 59.7 seconds). The reason behind the major discrepancy between the first three and last two types of hearers can be ascribed to the fact that (i) the young females (aged 11 and 17) are remarkably shy and reserved and (ii) their accompanying mothers are mostly side-participants as they are unaddressed hearers for the majority of counsellors' speech acts during the conversation.

6.4.1 Mother-and-infant (AMI) counselling sessions

Table 6.3 overleaf provides a list of hearer signals as they occur in pre-test HIV conversations between counsellors and mothers testing their infants in the data. It has been argued that under 'understanding', only instances of hearers showing true understanding through hearer signals are included. This is why the only instances of hearer signals being judged to show true understanding are in the form of phrases where 68% thereof were produced to express true understanding. As mentioned, although other hearer signals could be produced to show understanding, if it could not clearly be observed and interpreted to irrefutably be used in this way, it was not included in the total. The ten head nods also found to show understanding are those produced simultaneous with the phrases just mentioned.

³² AMI: Mothers testing infants at clinic A. AAA: Accompanied pre-/adolescents at clinic A. AAAM: Mothers of accompanied pre-/adolescents at clinic A. BMMC: Medical male circumcision volunteers at clinic B. BR: Referred patients at clinic B.

Table 6.3: Hearer signal functions in AMI counselling sessions

	Verbal non-speech	%	One-word	%	Phrase	%	Nonverbal	%
Following	0	0%	0	0%	0	0%	21	18%
Understanding	0	0%	0	0%	17	68%	10	8%
Agreement	3	11%	0	0%	0	0%	10	8%
Recognition	0	0%	0	0%	2	8%	4	3%
Assessment	0	0%	0	0%	0	0%	0	0%
Reaction to prompt	8	30%	14	48%	11	44%	37	31%
Acknowledgement	17	63%	14	48%	6	24%	61	52%
Confirmation	8	30%	9	31%	10	40%	26	22%
Personal expression	0	0%	0	0%	0	0%	0	0%
Interest	0	0%	0	0%	0	0%	0	0%
Emphasis	0	0%	0	0%	0	0%	0	0%
Total ³³	27		29		26		118	

6.4.2 Accompanied pre-/adolescent (AAA) counselling sessions

With an average amount of seven hearer signals per patient, it is obvious that the girls in these counselling sessions maintain minimal participation. This is supported by the fact that 13 out of the total 14 responses are not produced independently by the hearer as they are found to be uttered in reaction to some kind of prompt from the speaker, as can be seen in table 6.4 overleaf. In addition, all the hearer signals produced by these patients are nonverbal in nature as each signal takes the form of a nod, supporting the fact that these participate minimally and are very reserved.

³³ The total of hearer signals given in this table for each group indicates the total hearer signals produced by the hearers within that group. It is important to note that since hearer signals are often used for more than one reason, that the numbers provided above the total do not add up to the total, but indicate the number out of the total of hearer signals that was produced to show following, understanding, agreement, etc. that can overlap.

Table 6.4: Hearer signal functions in AAA counselling sessions

	Nonverbal	%
Following	0	0%
Understanding	0	0%
Agreement	0	0%
Recognition	0	0%
Assessment	0	0%
Reaction to prompt	13	93%
Acknowledgement	1	7%
Confirmation	1	7%
Personal expression	0	0%
Interest	0	0%
Emphasis	0	0%
Total:	14	

The mothers accompanying the pre-/adolescent girls show no instances of false following and a high rate of understanding throughout the conversations. The reason for their lack in hearer signals used as continuers in showing (false) following (presented in table 6.5 below) could be that these hearers are seldom the direct receiver of information from the speaker and as side-participants feel less obliged to produce this kind of feedback. These hearers are also the only participants to produce hearer signals with the aim to emphasise something said by the counsellor (cf. 6.3.11) and is found to take the form of each type of hearer signal.

Table 6.5: Hearer signal functions in AAAM counselling sessions

	Verbal non-speech	%	One- word	%	Phrase	%	Nonverbal	%
Following	0	0%	0	0%	0	0%	0	0%
Understanding	0	0%	0	0%	6	100%	6	27%
Agreement	0	0%	0	0%	1	17%	1	5%
Recognition	1	17%	0	0%	0	0%	0	0%
Assessment	0	0%	0	0%	0	0%	0	0%
Reaction to prompt	1	17%	0	0%	2	33%	9	41%
Acknowledgement	2	33%	1	100%	2	33%	12	55%
Confirmation	2	33%	0	0%	1	17%	2	9%
Personal expression	0	0%	0	0%	0	0%	0	0%
Interest	0	0%	0	0%	0	0%	0	0%
Emphasis	2	33%	1	100%	1	17%	3	14%
Total:	6		1		6		22	

6.4.3 Voluntary medical male circumcision (BMMC) patient counselling sessions

What is apparent about all three patients in this session type, is not only their participation in general (with the highest average of hearer signals provided per minute with 14.6 per person), but the diversity in which hearer signals are produced. A reason for this might be the fact that their presence at the clinic is more premeditated than other patients. The MMC service at clinics is advertised as a precautionary action as it decreases the chance of contracting HIV. The patients that undergo this procedure are aware of this and make the decision to be there accordingly. When the counsellor asks Pieter why he is there, he answers for “[his] own safety”, which directly reflects his knowledge of and motive for his visit to the clinic.

Although used by one patient, the only example of showing interest as well as assessment of information by producing a hearer signal is found in this group. Another noteworthy contribution found in this group is an example in which a patient shows empathic understanding, which is not otherwise found in the data. Since this instance is an example of the hearer taking the floor and contributing in this way, it is not included in the statistics of this analysis. The low amount of hearer signals reacting to prompts also supports their true participation as their hearer signals are generally provided independently. The only instance found in which a patient asked a question out of his own accord, is also found in this group. Table 6.6 below provides an overview of the diverse reasons for hearer signals produced by this group.

Table 6.6: Hearer signal functions in BMMC counselling sessions

	non-speech	%	1 word	%	phrase	%	Nonverbal	%
Following	1	3%	1	3%	0	0%	13	13%
Understanding	2	7%	3	8%	17	53%	13	13%
Agreement	1	3%	2	5%	1	3%	6	6%
Recognition	1	3%	3	8%	0	0%	4	4%
Assessment	2	7%	0	0%	0	0%	1	1%
Reaction to prompt	11	38%	9	24%	5	16%	25	25%
Acknowledgement	14	48%	36	95%	16	50%	67	68%
Confirmation	6	21%	1	3%	2	6%	12	12%
Personal expression	0	0%	0	0%	0	0%	1	1%
Interest	0	0%	0	0%	0	0%	1	1%
Emphasis	0	0%	0	0%	0	0%	0	0%
Total:	29		38		32		99	

6.4.4 Referred patient (BR) counselling sessions

Although this group often provides hearer signals (at a rate of 12.2 per minute), the amount of misunderstanding and false following is apparent throughout closer analysis of these sessions. Instances of false following are more common in these sessions as can be seen in table 6.7, below, and the number of hearer signals produced in reaction to prompts and neutral acknowledgement is high.

Table 6.7: Hearer signal functions in BR counselling sessions

	non-speech	%	1 word	%	phrase	%	Nonverbal	%
Following	7	13%	2	4%	2	6%	44	21%
Understanding	0	0%	1	2%	4	13%	5	2%
Agreement	0	0%	3	7%	1	3%	5	2%
Recognition	2	4%	3	7%	3	10%	5	2%
Assessment	0	0%	0	0%	0	0%	0	0%
Reaction to prompt	26	48%	23	50%	10	32%	101	49%
Acknowledgement	30	56%	24	52%	21	68%	96	47%
Confirmation	5	9%	4	9%	4	13%	19	9%
Personal expression	2	4%	3	7%	1	3%	3	1%
Interest	0	0%	0	0%	0	0%	0	0%
Emphasis	0	0%	0	0%	0	0%	0	0%
Total:	54		46		31		205	

An interesting irregularity, however is that although there are 31 phrases counted in this group, table 6.8 overleaf illustrates that 94% thereof (29 out of 31) are produced by the same person. This patient, Leon, is an L1 speaker of isiXhosa and although his Afrikaans is very close to native-speaker level, he is the only patient in this study to receive counselling in his L2. Leon, the producer of the majority of these signals, grew up in the area and it is apparent that his Afrikaans proficiency is completely adequate. He also shows very little deviations to an L1 speaker accent in the language. Despite his proficiency in Afrikaans, one might argue that the high frequency of feedback he gives could be explained by Anthonissen's (2010:114) observation that isiXhosa L1 patients would often choose to accommodate the HCP by communicating in the L1 of the HCP. This kind of accommodation might also be reflected in the number of hearer signals provided by the patient possibly produced as a form of encouragement toward the speaker. This discrepancy can also be interpreted as a form of a verbal tic (or personal idiosyncrasy) as most of the phrases provided by Leon are a variation of "daar'sy" which can be translated to "there it is" or "that's it".

Table 6.8: Hearer signal phrases in BR counselling sessions

	Jo-anne (BRF1)	Maggie (BRF2)	Letitia (BRF3)	Pedro (BRM1)	Leon (BRM2)	Total
Following	0	0	0	0	2	2
Understanding	0	0	0	0	4	4
Agreement	0	0	1	0	0	1
Recognition	0	0	0	0	3	3
Assessment	0	0	0	0	0	0
Reaction to prompt	0	0	0	0	10	10
Acknowledgement	0	0	2	0	19	21
Confirmation	0	0	0	0	4	4
Personal expression	0	0	0	0	1	1
Interest	0	0	0	0	0	0
Emphasis	0	0	0	0	0	0
Total:	0	0	2	0	29	31

6.5 INVENTORY OF HEARER SIGNALS

As explained above, all the verbal hearer signals found in the data were divided into non-speech, one-word utterances, as well as phrases. Table 6.9 overleaf provides the number of each of the kinds of verbal hearer signals as well as the conversation type (in which various kinds of hearers are found) in which they were produced.

Table 6.9: Inventory of verbal hearer signals per group

Verbal Hearer signals	AMI	AAAM	BMMC	BR	Total
<u>Non-speech</u>					(116)
Hm(m)	25	6	21	46	98
U(u)h	2	0	3	7	12
O(o)h	0	0	3	0	3
Ah	0	0	1	0	1
Repetitions	0	0	1	1	2
<u>Speech: one-word</u>					(114)
O(o)ka(a)y / 'kay	14	0	17	17	48
Ye(e)s	13	1	15	17	46
No	1	0	0	1	2
All right	0	0	0	2	2
2 combined/repeated	1	0	5	8	14
3 combined/repeated	0	0	1	1	2
<u>Phrases: Continuers</u>					(42)
That's right, it is so, there it is	0	0	5	19	24
Okay ... / that's right ... / it's all right	0	0	7	4	11
I understand / I see	0	0	7	0	7
<u>Phrases: Content specific</u>					(53)
Repetition of S's utterance after	9	4	5	2	20
Simultaneous to S	7	1	2	0	10
In pause/abandoned utterance	2	0	2	1	5
Same endings offered just after S	6	1	2	0	9
Unsure: Unintelligible	2	0	2	5	9
Total Verbal Hearer signals	82	13	99	131	325

The most used hearer signal is the non-speech item, “hm(m)”, making out 98 hearer signals (30%) out of 325. The second most uttered verbal hearer signal takes the form of the one-word utterance, “okay” together with its variations making out 48 (15%) of the hearer signals, followed by variations of “yes” at 46 instances. Regarding the phrases uttered through the back channel, “okay”, “that’s right” and it’s all right” as it stands in table 6.9 include longer phrases in which these words or phrases form the main part, e.g. “Okay, my nurse”. The content-specific phrases were divided into the placement of the hearer signal and distinguishes between the most general repetition of a part of the speaker’s utterance after the speaker’s utterance thereof, utterances simultaneously produced with the speaker, phrases provided in a speaker’s natural pause or abandoned utterance, as well as similar sentence endings provided just after the speaker started articulating it, a delayed phrase rather than a repeated utterance.

Figure 6.1 below offers a visual representation of the distribution of verbal hearer signals throughout these conversations. According to what is found in the data, the most generally produced verbal hearer signals are non-speech and one-word utterances (making up 36% and 35% of the total verbal hearer signals respectively), followed by content-specific and continuer phrases (16% and 13% of the total respectively).

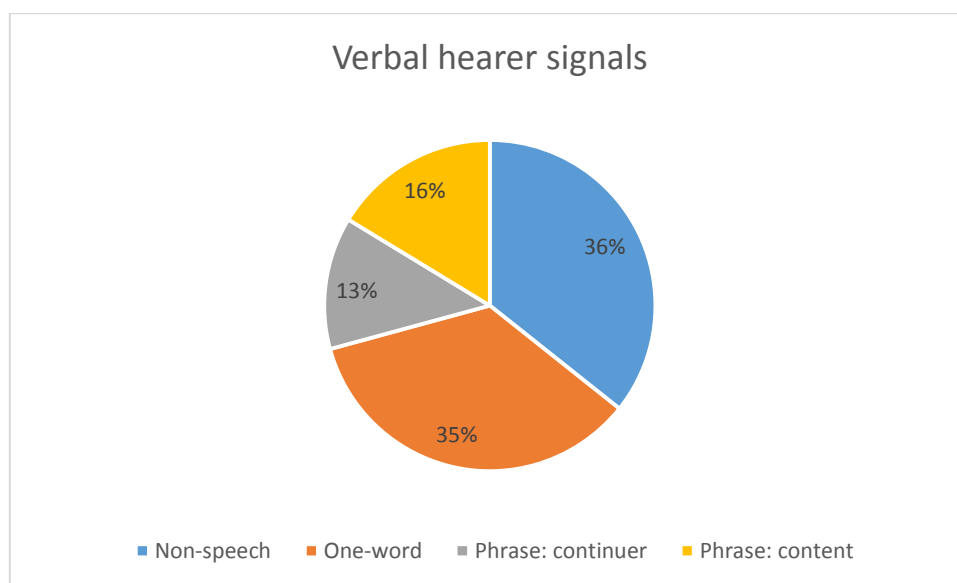


Figure 6.1: Distribution of verbal hearer signals

Regarding nonverbal hearer signals, table 6.10 below summarises the number of head nods and head shakes produced within the various conversation types. The total within each group was then divided by the number of patients as hearers in that group to calculate the number of head nods per person in order for ease of comparison of the distribution of head nods.

Table 6.10: Nonverbal hearer signals per group

Nonverbal hearer signals	AMI	AAA	AAAM	BMMC	BR	Total
Head nods	113	14	22	97	205	451
Head nods per person	28	7	11	32	41	
Head shakes	5	0	0	2	0	7
Total	118	14	22	99	205	458

The numbers above show that referred patients produced the most head nods per person (41), followed by medical male circumcision patients (32 per person), mothers testing their infants (28 per person), and mothers (11 per person) accompanying their pre-/adolescent daughters (7

per person). Patients did not often shake their heads as hearer signals. Head shakes were produced only by medical male circumcision patients (2 occurrences) and mothers testing their infants (5 occurrences).

In summary, figure 6.2 below gives a visual representation of the general distribution of hearer signals found in the data, and table 6.11 overleaf gives an overview of the functions that these signals most often represented within their context. Although it was hypothesised in chapter five that the structure of this type of interaction does not allow for real participation from the patient (as hearer), the quantitative data analysed in this chapter, in contrast, show that participation in the form of hearer feedback takes on many forms. Some of these signals, of which the vast majority (57%) were head nods, can be seen as forms of passive participation.

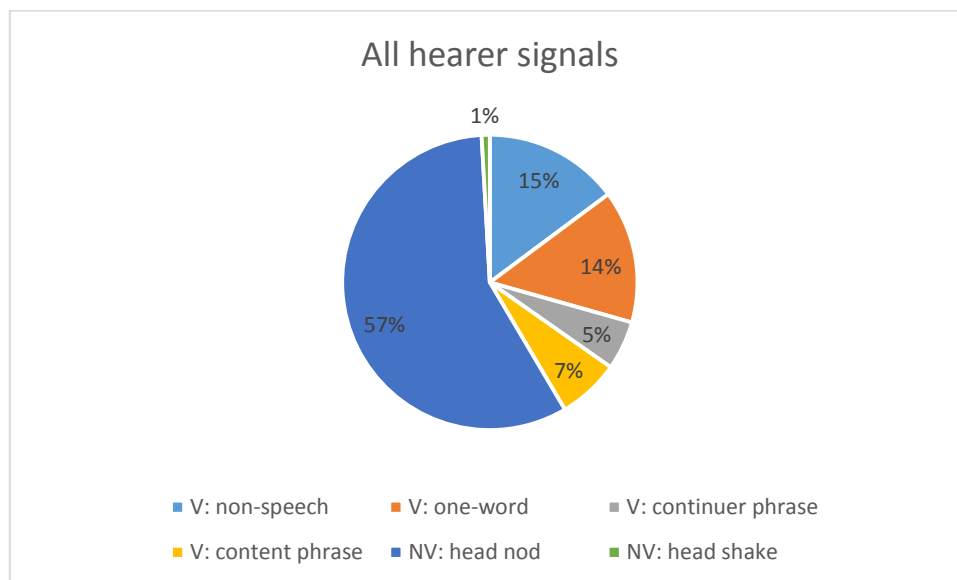


Figure 6.2: Distribution of all hearer signals

The structure of this type of interaction thus allows patients' contribution to mostly take the form of feedback which can be highly meaningful and even show active forms of contribution in some cases. Although 11 functions underlying the production of hearer signals were identified in this chapter, it is clear throughout that some of those functions were minimally used. Hearer signals uttered as assessments, emphasis, recognition, agreement and to show interest, for example, are scarce in comparison to the majority produced, as indicated in table 6.11 overleaf in which the top three hearer signal functions for each type of hearer signal are provided. The most generally used verbal hearer signals (non-speech and one-word

utterances) are mostly used as acknowledgers, a reaction to a prompt provided by the speaker, as well as utterances used to confirm something said by the speaker. Phrases provided through the back channel, however, since they contain semantically analysable feedback, can be observed to show understanding, and are often produced in this capacity.

Table 6.11: Hearer signal functions

Hearer signal	1	%	2	%	3	%
<u>Verbal HS</u>						
Non-speech	Acknowledgement	54%	Reaction to prompt	40%	Confirmation	18%
One-word	Acknowledgement	66%	Reaction to prompt	40%	Confirmation	12%
Phrases	Acknowledgement	49%	Understanding	48%	Reaction to prompt	30%
<u>Nonverbal</u>						
Head nods	Acknowledgement	53%	Reaction to prompt	41%	Following	17%
Head shakes	Confirmation	57%	Following	29%		
	Agreement	57%				

6.6 CONCLUSION

As articulated in chapter five, the most prevalent feature of the pre-test VCT counselling session as a conversation type is the imbalance of speaking turns and speech production between the participants. It is found that the bulk of this conversation consists of information-giving sequences filled with narrative cycles by the counsellor as the speaker, accompanied by contributions from the other participant, the patient, as hearer which takes the form of verbal and nonverbal acts aimed at supporting the flow of the conversation and providing feedback as to how the interaction is progressing.

This chapter provided a categorisation of these contributions, the hearer signals, according to session type and function. Verbal hearer signals were categorised in terms of non-speech items (“hm”), one-word utterances (“okay”) as well as continuer phrases (“I understand”) and content-specific phrases. Nonverbal hearer signals were found in the form of head nods and head shakes. Figure 6.1 above offers a visual representation of the distribution of all the hearer signals as found in the four conversational subtypes analysed in this study. As shown below, the most widely used hearer signals were produced in the form of head nods (57%), followed by verbal non-speech (15%) and one-word utterances (14%). The hearer signals least produced in this kind of conversation are content-specific phrases (7%), continuer phrases (5%) and head shakes (1%). This finding supports the general feature of patients or

hearers in this context who take the passive role as follower in contrast to the counsellor who leads and guides the development of the conversation. Hearers enforce this passive role by producing verbal hearer signals that are mostly non-speech or one-word utterances, as well as nonverbal hearer signals, avoiding longer utterances or phrases.

Head nods as nonverbal hearer signals are then also found to contribute as acknowledgers and reactions to prompts. These signals have also been found to convey that a hearer is simply following the speech provided by the speaker, without showing specific understanding of the content. Lastly, the small number of head shakes was found mostly to be produced in agreement or as confirmation of a speaker's utterance. The findings regarding the form and function of hearer signals found in pre-test VCT counselling sessions will be linked to the findings of the previous chapter in the summary provided in chapter seven.

Chapter Seven

SUMMARY OF FINDINGS AND CONCLUSION

7.1 INTRODUCTION

In order to address the rapid proliferation of HIV throughout South Africa across the period of almost 20 years since the first cases of AIDS were diagnosed, VCT services were created to establish individuals' HIV status as early and as widely as possible, as well as to counsel patients on the causes and effects of an HIV positive result and to guide them through to possible ART. As the epidemic grew, however, so did the workload of medically trained HCPs and the requirement of larger numbers of counsellors. This led to the training of lay counsellors to facilitate the VCT process which is structured into three parts. The counsellor's aim during (i) pre-test VCT counselling is to ensure that the patient has adequate information and fully understands the nature of the test that is to follow in order to make an informed decision in giving consent (Western Cape Government, 2016b). After the necessary information has been conveyed, understanding thereof is shown by the patient and consent is given, (ii) the test is administered during which the counsellor and patient remain in each other's presence. Once the outcome of a clinical blood test is available, (iii) there is post-test HIV counselling which is centred on the announcement of the test results.

These three kinds of HCP-patient conversational subtypes found within general medical discourses that are also conversationally enacted, have not yet received much attention in the study of conversational structure and characterising features. Although the uniquely trained counsellors leading these counselling sessions have technical skills and sufficient knowledge of HIV (both bio-medical and in terms of treatment), they might not have the necessary communicative skills needed to achieve the aims of the consultations in this kind of context (Argyle, 1983:57). The importance of analysing the inner workings of these conversations should therefore be emphasised in order to come to some kind of conclusion as to the effectiveness of the current service provided. By collecting a corpus of spoken language in authentic pre-test VCT counselling sessions, this study aimed to identify and characterise the generic features of pre-test VCT counselling sessions as a conversation subtype within the genre of medical discourse.

Since one of the aims of the counsellor during pre-test VCT counselling sessions is to inform the patient about various HIV-related topics before informed consent for administering the test can be given, these conversations were investigated also to consider whether the aim of explicitly establishing patients' knowledge of the illness and various kinds of care is generally achieved. Observation has shown a clear imbalance regarding spoken participation of the various interactants. Although the same person in one speech event is at certain times the speaker and at other times the hearer during natural conversation, the counsellors in these conversations are found to generally dominate the conversation in terms of speaker turns, sequence structure and general development of the conversation.

Such participatory imbalance results in the patient, who is unfamiliar with the context and its procedures, mostly taking a passive role as listener in the conversation. In this case, when the listener role is the primary one for a particular participant, hearer contributions typically take on the form of producing meaningful signs and signals addressed at the speaker, but with very discrete functions. These take the form of particular sounds, words and phrases as well as accompanying nonverbal signs and signals such as head nods and head shakes. After establishing the generic features of pre-test VCT counselling sessions, this study aimed to identify the forms of the hearer signs and signals that occur in such spoken communication in order to interpret them and to identify the most widely used signs and signals to determine the contribution they make in the conversation.

In order to create a foundation on which the analyses in chapters five and six could be based, a situational background of the study as well as discussion of specific relevant literature from already existing research were provided. Chapter two focused on creating the situational context in which background information was given regarding geography, population and linguistic diversity in the area in which this study was situated. Data were collected from two HIV day clinics in two rural towns in the Cape Winelands municipal district of the Western Cape, a South African province in which the number of infections of respondents ages 15 to 49 has more than doubled from 2005 (3.2%) to 2012 (7.8%) (Shisana et al., 2014:46). Chapter two further reported on the challenges facing the South African health care system, and narrowed the focus to reflect on linguistic diversity as an obstacle for successful VCT services in the Western Cape.

Chapter three first provided background to the linguistic subfield of Pragmatics as scientific field in which this study is grounded. After introducing the study of spoken interaction as well

as the importance of taking into account the social situation in which conversation takes place, the way in which participants create interactive alignment during dialogue was discussed. Second, this chapter introduced the theoretical framework of CA with its focus on the sequential ordering of instances of spoken language in everyday talk-in-interaction. This exposition was given because the methodology of CA and the rules of sequencing components of conversations were applied in the analyses given in chapter five. In focussing this section to better fit the nature of the study, Institutional CA and the advantages of applying CA to the analysis of institutional talk was also introduced. Third, a review of existing literature on the structure and features of medical discourse in the form of HCP-patient communication was provided. Chapter three then concluded with an exposition of hearer signals as a linguistic phenomenon by giving an array of the definitions that are in circulation, as well as discussing research regarding its various forms and functions.

Before presenting analyses of the data in chapters five and six, chapter four provided an overview of the research design and methodological approach taken in this study. In addition, this chapter provided detailed information regarding the context and participants of this study as well as the process of data gathering, including ethical considerations. Finally, this chapter provided a structural overview of the way in which data were analysed, including the transcription process and analytic strategies on which the methodological approach of this study was based.

7.2 GENERIC FEATURES OF PRE-TEST VCT COUNSELLING SESSIONS

Chapter five finally gave the characterisation of the pre-test VCT counselling sessions as a conversational subfield within the larger genre. Within these conversations, four further, more specific categories (distinguished on the basis of five different types of hearers) were found in the data. These categories coincide with the kind of patient and the reason for the patient's visit, as this influences general talk and question-answer sequences at the beginning of the conversation. These four HIV pre-test counselling categories include as participants: mothers testing their infants at clinic A (AMI), accompanied pre-/adolescent females (AAA) as well as their mothers as side-participants (AAAM) at clinic A, medical male circumcision volunteers at clinic B (BMMC), as well as female and male patients who were referred by other HCPs or visiting for general medical concerns at clinic B (BRF & BRM).

In an attempt to identify and characterise the features of pre-test VCT counselling sessions as a conversational subfield within the medical discourse genre, the analysis in chapter five applied instruments suggested by CA in order to describe and interpret recurring patterns within this specific discourse. Chapter six then used instruments provided by Corpus Linguistics to identify and list verbal and nonverbal hearer signals before characterising them according to form and function within the discourse. Throughout the analyses, attention was given to similarities and dissimilarities between the various components of the conversations found at both clinics.

Before providing a summary of findings, a statistical representation of counsellors' and patients' verbal contribution in these conversations, as drawn from the transcribed corpus, was given. This was specifically provided as concrete evidence of the previously mentioned participatory imbalance between the interlocutors. To briefly restate: by administering a word count of each session, it was found that on average, counsellors uttered 82.8% of the verbal contributions versus patients' (including the two "overhearing mothers", i.e., side-participants) contribution of 17.2% in these counselling sessions (cf. table 5.1 in section 5.8 for more details).

In order to further analyse the way in which counsellors direct the conversation and thus characterise these pre-test VCT counselling sessions, four types of sequences found within its structure as a whole were identified which each received specific attention, namely opening, closing, question-answer, and information-giving sequences. Throughout these sequences and especially within the last mentioned sequence type, various hearer responses were also taken into account, all of which will be accounted for below.

7.2.1 Opening sequences

The first generic feature of opening sequences that was apparent across each subtype was that each conversation is initiated by the counsellor. Before the counsellor starts, the patients would keep their attention on the counsellor in anticipation of this initiation. The initial utterance generically takes the form of either an SA sequence in which the counsellor tries to get the attention of the patient or announces the start of the conversation, or a greeting to which patients mostly respond in kind.

What was found to follow these initial sequences were in the form of (i) questions regarding the patient's state followed by a pause during which the counsellor relinquishes the floor in

selecting the patient as next speaker, (ii) informative introductory statements during which the counsellors introduce themselves and their role at the clinic. This is usually followed by (iii) a question or informative statement inquiring as to or informing patients regarding the reason for their visit. Deviant case analysis provided further insight as to the prominence of a combination of these three turn-types throughout the opening sequences.

Regardless of the combination or form of the turns found to make out the opening sequences in general, what was found to be generic throughout all counselling sessions is the way in which the patient orients her/himself toward the passive role in the conversation. The counsellor, as the participant who is familiar with the institutional goals of this kind of conversation typically takes the managing role in leading the conversation. This is clear from the onset of the counselling session during which each patient waits for the counsellor to initiate the conversation, and the fact that throughout the opening sequence, patients' contribution tends to take the form of some kind of reaction to a turn initiated by the counsellor as speaker. Patients in openings typically (but not always) (i) respond to a counsellor's summons, (ii) return a greeting in reaction to the counsellor's greeting, (iii) answer questions posed by the counsellor and sometimes (iv) react to informative utterances provided by the counsellor.

7.2.2 Closing sequences

The same as with opening sequences, closing sequences were clearly observed to be initiated by the counsellor in each case. The counsellor typically initiates this sequence after s/he has completed the last question of the questionnaire or a summary of the test procedure. In each case the closing is introduced with a discourse marker such as "so" or "okay". After the initiation of the pre-closing or closing sequence, patients are found to collaborate in that they agree to the counsellor's transition from the information-gathering phase of the conversation to the concluding phase. After the initiation of the closing sequence, the most general turn-types found in these sequences take the form of requests or instructions from the counsellor to which the patient complies, followed by the provision of procedural information in statement form. In some cases, questions from the counsellor occur in which the patient is asked whether s/he understands or has any questions to which the answers are always positive and negative respectively.

What is prominent throughout these different conversational turns within the closing sequence is again the way in which it is managed by the counsellor as speaker. One case in which a patient does not passively cooperate with this transition illustrates clear disorientation as reaction from the counsellor. The presence of this single deviant case throughout these conversations, as well as the way in which it is reacted upon further highlights the counsellor-centred nature of these conversations.

7.2.3 Question-answer sequences

Question-answer sequences are typical in medical communication, and particular in HCP-patient consultation. Four generic types of question-answer sequences were found throughout the pre-test VCT counselling sessions. First, question-answer sessions similar to history-taking sessions as generally found in doctor-patient consultations occur. Second, counsellors ask questions in order to solicit the patient's knowledge of HIV possibly since one of the aims of pre-test VCT counselling is to ensure suitable understanding from the patient in order for them to make informed decisions regarding consent. A third type of question found throughout the conversation is a form of checking in from the counsellor, during which s/he asks the patient whether s/he understands or whether s/he is okay. The fourth generic type of question-answer sequence is usually found before the closing sequence and takes the form of a questionnaire-type question sequence during which the counsellor fills in a form before the test can be administered.

During the conversations found in the data, history-taking type question-answer sequences usually occur after the opening sequence and are aimed at orientating the counsellor as speaker in terms of patient-specific background information. Questions in these sequences were sometimes found to be formulated as a (i) statement that patients can merely confirm by providing a positive response, or as a (ii) question to which possible answers are provided by the counsellor. Both these question-types were found to influence the patients in that a specific answer is prompted to which patients mostly respond with a positive response of affirmation. In this way, patients are not provided with a chance to formulate their own answers and are found to continue responding passively.

This is a problem associated with pre-test HIV conversations as patients are bombarded with information without being given the opportunity to raise personal concerns or questions. Patients are rarely asked to relay their own understanding, which means that counsellors only

focus on one of the two basic goals of counselling; while they inform patients of the nature of HIV, they fail to check patients' understanding of that information. In a community where the pre-test counselling event might be the only opportunity for gaining information regarding HIV, it is crucial that patients understand well. Assuring the distribution of this knowledge is the first step in addressing the spread of HIV. By not checking this knowledge, counsellors cannot say for certain that the pre-test counselling session was successful.

The way in which counsellors solicit patients' knowledge through asking questions is also significant. If these kinds of questions are asked, they are usually placed before the educational phase as a kind of introduction to the information-giving sequence to follow. Across the 14 conversations in the data, however, only three instances occurred in which a patient was prompted to provide her/his knowledge of HIV. While three conversations completely lack this kind of question, the way in which this question was asked in the remaining eight conversations only required a yes/no answer, after which the counsellor continued questioning or introduced the information-giving sequence. Furthermore, although patients responded differently to this question, counsellors were often found to follow up with the same structural procedure.

Throughout different kinds of sequences found in this type of conversation, counsellors check in with the patients by for example asking them whether they understand or are comfortable. Examples here often show that (i) no space is provided after the first pair part in which the patient is expected to respond, or, as shown before, (ii) subjective statement-like questions are formed which steer patients towards a specific response. Both of these occurrences indicate conversations that are not patient-centred as (i) patients are denied a speech turn in the production of a second-pair part response, and when they are given this natural opportunity, (ii) patients are encouraged to give a certain answer.

The typical HCP-approach is shown to be crucially flawed in HIV counselling at the moment. In a situation that is unfamiliar and probably intimidating to patients, their communicative and care needs are not sufficiently foregrounded and attended to. The (unintended) pattern of exclusion indirectly gives the patient low standing as her/his concerns, opinions and anxieties are not addressed. The atmosphere in which the conversation takes place is one in which the counsellor apparently tries to rush through the prescribed phases as quickly as possible to get to the test and complete the session. This quality of the conversation is, however, not the fault of the counsellor her/himself, but probably of the system as it has developed within a given

set of circumstances. Often there are not enough counsellors to tend to all the patients, which results in them not being treated respectfully in terms of their individuality. This is something that needs to be confronted. In the end, the way in which patients are treated in these conversations might lead to their alienation from clinics and the loss of the value HIV counselling is meant to have.

The questionnaire-type question-answer sequence usually found at the end of the conversation takes the form of the counsellor asking the patient the questions on the medical form. This is generically done according to the protocol and does not solicit any knowledge from the patients, but rather requires the patients to provide answers regarding their medical status. These sequences were also found to be uniform throughout the data. What was apparent throughout each type of question-answer turn or sequence explained above, is the fact that questions are scarcely asked in a way that prompts a hearer's understanding of speech during the turn. This fundamental assumption of other-monitoring brought about by adjacency pairs such as questions and answers in natural conversation is clearly lacking as questions in pre-test VCT counselling sessions are not often used to oblige the hearer to display her/his degree of understanding of the ongoing conversation. It can consequently be assumed that counsellors are not aware of patients' degree of understanding throughout the conversation.

7.2.4 Information-giving sequences

As previously mentioned, VCT protocol requires counsellors to cover a specific number of HIV-related topics before the test can be administered. The fact that counsellors are trained to work their way down this checklist leads to an apparent imbalance of speech turns as the conversational bulk of pre-test VCT counselling sessions take the form of sequences in which the counsellor provides information to the patient during which the patient as receiver of information responds with various feedback signals provided in the back channel.

On a structural level, these information-giving sequences generically do not allow the patient to take the floor as counsellors keep self-selecting as the next speaker which provides for the general presence of a concentrated amount of hearer signals. Another phenomenon that occurs frequently is the production of different types of prompts by the speaker that encourage the production of these hearer signals. These prompts often take the form of tag-questions, other prompt words, intonation change and pause provision, as well as the counsellor directly addressing the hearer. During these sequences the hearer is therefore again found to contribute

passively by providing hearer signals with various functions, which was then analysed in more detail in chapter six.

7.3 HEARER SIGNALS

The importance of analysing hearer signals was emphasised in chapter five as it was found that the conversation type known as pre-test VCT counselling reveals an imbalance in patient participation in that the majority of the conversation is made up of long monologic information-giving sequences by the counsellor. During these monologic parts the patient is constructed as a hearer who typically contributes mostly by producing meaningful signals towards the speaker. Hearer signals in this data are regarded as verbal and nonverbal signals (or “conversational objects” (Gardner, 2001:13)) that a hearer produces to acknowledge reception of a speaker’s information with the goal of confirming that s/he is in fact the listener (Bublitz, 1988:169). The way in which the participants further treat these utterances was taken into account, e.g. if a potential hearer signal receives any reference in following speech, it was not considered a hearer signal.

Regarding their form, hearer signals found in the data were divided into two categories, verbal and nonverbal. Verbal hearer signals were then further divided into non-speech utterances (such as “hm(m)” and “uh”), one-word utterances (“okay” and “yes”), and phrases which consists of continuer-type phrases (“yes I understand”) and content specific phrases. Nonverbal hearer signals include head nods and head shakes used by patients without attempting to take the speaking turn. The vast majority of hearer signals produced took the form of head nods as nonverbal items (57% of all hearer signals), followed by verbal non-speech utterances (15%) and one-word utterances (14%). The hearer signal least produced in this kind of conversation were content-specific phrases (7%), continuer phrases (5%) and head shakes (1%). This finding supports the general feature of patients or hearers in this context who take the passive role as follower in contrast to the counsellor who leads and guides the development of the conversation. Hearers enforce this passive role by producing verbal hearer signals that are mostly non-speech or one-word utterances, as well as nonverbal hearer signals, avoiding longer utterances or phrases.

Regarding their function as produced in the data, hearer signals were most frequently used to (i) signal acknowledgement of information received, to (i) react to some kind of prompt produced by a speaker, to (iii) signal confirmation towards something said, or to (iv) show

understanding or (v) the fact that the hearer is following, whether or not the hearer truly understood. Other hearer signal functions found that were used less often include indicating a hearer's (i) personal expression, (ii) recognition of the content of speech, (iii) assessment of speech, as well as (iv) interest in, (v) agreement with or (vi) emphasis of what is being said.

7.4 SOCIAL CONCERNS

Throughout this chapter, evidence has been given that confirms pre-test VCT counselling to be a specific discourse genre with certain generic sequence-styles and characteristics that are dictated and controlled by the counsellor who mostly holds the role of speaker. These counsellors are taught this rigid structure in training as a strict protocol that must be followed in these sessions. Characteristically, patients are not often found to take the floor or challenge these strict constraints set out by the counsellor. In this way, the patient as hearer is generally left agentless throughout these conversations.

Additionally, although different patients provide various responses and hearer signals throughout conversation through which some indicate to having sufficient knowledge whereas others do not, hearers on various sides of this spectrum are often found to be treated in the same way and made to receive the same generic information-giving sequence. It is clear throughout the various conversation subtypes found in this small study sample that a variety of patient- and hearer-types visit these clinics, each presenting different backgrounds, needs and understandings.

What is found within this structure, however, is that counsellors typically approach each session with a 'one size fits all' mentality in which a diverse group of patients are treated according to the same protocol. On these grounds one can argue that the counsellor does not focus on the patient as individual with individual needs, but rather as an entity within the process of VCT that needs to undergo the same routine as explained in chapter five. The drive of the counsellor as speaker is thus not necessarily to counsel the patient by offering psychological or mental guidance; it appears to be of a more bureaucratic nature in that the counsellor is found to go through the motions in order to ultimately fill in the patient's forms. Thus it seems that the counsellor's audience is not the patient, but rather the administrative staff who will be checking and filing the data collected through the questionnaire at the end of the pre-test counselling session.

The VCT program is commended for how it has aided in successfully providing ART to a diverse group of people throughout the whole of South Africa. Governmental and non-governmental contribution towards facilitating these service in clinics shows the nature of social concern from those morally and officially responsible for the health care of the communities served in the HIV clinics. Additionally, and valuable to the various communities in more than one way, is the training and employment of counsellors outside of the medical practice, as this truly contributes to the eradication of the previously uneven distribution of power within consultation, testing and treatment within VCT. Also, as the counsellors are often members of the local communities, providing this kind of training is a form of capacity development and provision of employment while at the same time providing much needed services.

It needs to be mentioned that from a social, caring perspective the counselling work is done commendably. From a communicative, effective perspective, however, as a researcher I am obliged to take a more critical approach. Although there have been examples of counsellors taking a listener role and giving agency to the patient in this way, what has come to light during a closer analysis of these counselling sessions, is that the diversity among patients often requires additional counselling-related support that counsellors are not necessarily equipped to provide. Although they clearly do not lack the biomedical knowledge that has to be conveyed to patients, counsellors need to be equipped with social skills necessary in order to successfully manage the counselling of diverse patients in this context. Counsellors could be trained to become aware of taking a more patient-centred approach.

This kind of training does not need to be complex and time-consuming. The trainers are required to attend refresher courses and additional training throughout the year and this type of patient-awareness training can easily be included in these courses. Through role-play, for example, counsellors in groups of two can take turns in playing the counsellor and the patient. By putting the counsellors in the shoes of the patients, they should become aware of the effect of their counselling style in general. Together with this, counsellors can be equipped with simple strategies for including the patient in each phase of the counselling process.

With the opening sequences, for example, in which the trend of the conversation is set, counsellors should be aware to include the patient from the start. They should be encouraged to not just tell the patient why they are there, but ask them and especially be mindful to give the patient the opportunity to fully answer the questions and possibly voice her/his concerns.

In this way, from the beginning, a space in which patients feel comfortable to take the speaking turn. Additionally, counsellors could include patients in the information-giving sequences as well by asking them to relay their understanding of a topic previously talked about or one that is still to be handled.

By breaking up the pre-test HIV counselling session into the phases as analysed by CA in this study, workshops and training sessions can be divided into easily manageable parts during which counsellors can be equipped with new strategies and approaches that will move the focus to the patient. Counsellors could be made aware of the great imbalance of speakership during their counselling sessions of which they are most probably not aware. This new knowledge can then be used as a starting point on which a new aim can be introduced: focusing on changing pre-test HIV counselling sessions as a type conversation from a lecturing type towards a more equally balanced conversation. In this way, by simply training counsellors to rather focus on the agency of the patient as hearer, crucial resources that already show positive results and growth in providing an invaluable service could be managed more efficiently.

7.5 LIMITATIONS

The study has of course not been without its limitations. To begin with, the complete dataset collected for this study included conversations in languages other than Afrikaans. These conversations were not included in the study, however, due to the excessive volume of the recordings and the complexity of the variables. As a preliminary study of the use of hearer signals in pre-test HIV counselling sessions as a conversation type, this study is effective. However, a study of this type in a South African context would ultimately include the issue of multilingualism in order to provide accurate reflections within a community. There is much more that can be said, especially within the South African multilingual landscape found in these types of rural areas. This is a valuable sector to observe and analyse, as a great number of South Africans inhabit these areas and are often overlooked. There is much more to learn within this field.

The sample size of the data gathered for this study accounted for a distribution of participants and conversation subtypes which cannot count as representative of all clinics and every possible VCT consultation. Out of a total of 14 counselling sessions, the six at clinic A were all counselled by Gretha, while the eight at clinic B were unevenly distributed between Mary

(six sessions) and Charles (two sessions). Even if minimal, there is a limitation in the fact that each counsellor is not represented equally in the data as the two female counsellors both facilitated six sessions in comparison to the male counsellor only facilitating two. Additionally, he was reported to be the best of the counsellors, meaning his underrepresentation could have skewed the data.

The conversation types were further not represented equally in that there were not equal number of each kind of category: four mothers who brought their infants, two who accompanied pre-/adolescents, three medical male circumcision patients and five referred or general patients made up the set of patient-participants. This unequal distribution between counsellors and conversation types could, if one had more data, prove to be skewed. It does, however, need to be mentioned that the researcher was given a specific timeframe during which data collection needed to be completed. The clinic environment is one where many concerns exist about patient confidentiality and the researcher considered this throughout. A fair number of individuals visiting the clinics during the time the researcher was present did not agree to take part in the study, meaning that the total of patients visiting the clinics is not the total number of sessions that took place during the same time.

Regarding logistics, the size of the counselling rooms complicated the data collection and could have had an effect on the nature of the data. Ideally, the researcher would have preferred to visually record both the counsellor as well as the patients during the counselling sessions. The size of all three counselling rooms, however, did not make the set-up of two video cameras in opposite corners of the room possible. It would have been interesting to take nonverbal behaviour such as eye contact and gaze of both participants into account in analysing the circumstances during which hearer signals were provided. Literature suggests that a speaker's gaze can influence the production of a hearer signal (Schegloff, 1982:79), which would have been interesting to include, but was not possible.

Furthermore, the degree to which the intention behind verbal and nonverbal hearer signals are intuitively, pragmatically and contextually determined could count as limitations to this study. Although each signal was contextually considered and analysed multiple times, its abstract and idiosyncratic nature proved difficult for accurate judgement of its function. Since, as mentioned before, most hearer signals were only judged to carry a certain function if that function was clear within the context, it could be that more subtle contributions behind the production of hearer signals could have been missed. With this being said, it is nevertheless

important to acknowledge that the subtle nature of hearer signals in this way is prevalent throughout all kinds of face-to-face interaction, and is not context specific.

7.6 SUGGESTIONS FOR FURTHER RESEARCH

The value of the data collected for this study must be emphasised as it opens the possibility of various future research endeavours. Studies relevant to the current data might include the identification of (e.g.) the most occurring lexical items to determine what the core vocabulary used in and thus also required for these consultations are. Accordingly, regularly used phrases and metaphors could be identified and analysed to determine the kinds of mental imaging that counsellors and patients draw on in this context. Here, CA can again be used as an instrument in describing and interpreting the most regularly occurring linguistic forms in HIV pre-testing consultation discourses.

Attention can further be given to making a distinction between consultations in which the linguistic repertoire of the counsellor and patients are the same, and those in which the linguistic repertoire between participants differ, i.e. where both rely on their first language in the communicative event and where participants have to rely on a lingua franca in this particular kind of event. In the case of the latter, (of which two examples were collected during the data collection of this study) it would be interesting to investigate the use of interpreting. If interpreting does occur, the participants and features of such communication could be analysed; if there is no interpreting, the ways in which discordance of the repertoires are managed in the counselling event, would need to be investigated.

Whichever direction is chosen, it would be fruitful to return to the clinics in order to collect additional data with the aim to broaden the database in order to include among others (i) more conversations between counsellor and foreign patients who both converse in their L2, English, (ii) more interpreter-based conversations, and to provide (iii) a broader set of samples in general.

7.7 RECOMMENDATIONS

On an institutional research level, not only can the findings and results of this study contribute to academic insight in terms of the forms, features and linguistic tools used within selected South African languages in this context, it can also provide information that could be used in

improving health care communication. At that, the contribution is in a vulnerable area where treatment is dependent on achieving mutual understanding among speakers who communicate within a rigid, counsellor-structured conversation-type.

The application of the findings can stretch as far as developing new training programs by for example, The Western Cape ATICC, a centre that plays a leading role in the prevention of the spread of HIV. In support of their goal to train counsellors, this knowledge can be used as empirical evidence of the consequences of specific speech actions and kinds of behaviour that inhibit patient participation. Through this, counsellors could be trained to be cautious to strive towards the maintenance of a patient-centred approach in their consultations.

7.8 CONCLUSION

By offering a summary of the findings presented in the analyses set out in chapters five and six, this chapter aimed to show how the expositions given in those chapters contributed to achieving the aims of the study in answering the research questions.

In view of the findings of this study, one can refer back to the aims of pre-test VCT counselling sessions. Counsellors should aim to not only ensure that the patient has adequate information regarding the nature of HIV together with other HIV-related issues, but also to ensure that the patient's knowledge of this information is adequate to such an extent that it will enable her/him to make an informed decision regarding their informed consent for the test that has to follow. The results of this study suggest that more emphasis is being put on the first aim of VCT counselling, as the majority of the conversation consists of information-giving sequences of this kind. With this being said, the second communicative goal of VCT seems to be neglected as there exists less evidence of appropriate knowledge-soliciting question-answer sequences during which patients can relay their understanding on which counsellors can judge the degree of their understanding.

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Appendix A

APPROVAL NOTICE: STELLENBOSCH RESEARCH ETHICS COMMITTEE



Approval Notice Response to Modifications- (New Application)

06-Nov-2013
Theron, Janina J

Proposal #: HS958/2013
Title: Listening in HIV counselling and testing - hearer signals in multilingual medical consultation

Dear Miss Janina Theron,

Your **Response to Modifications - (New Application)** received on **01-Nov-2013**, was reviewed by members of the **Research Ethics Committee: Human Research (Humanities)** via Expedited review procedures on **06-Nov-2013** and was approved.
Please note the following information about your approved research proposal:

Proposal Approval Period: **06-Nov-2013 -05-Nov-2014**

Please take note of the general Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

Please remember to use your **proposal number (HS958/2013)** on any documents or correspondence with the REC concerning your research proposal.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

Also note that a progress report should be submitted to the Committee before the approval period has expired if a continuation is required. The Committee will then consider the continuation of the project for a further year (if necessary).

This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki and the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health). Annually a number of projects may be selected randomly for an external audit.

National Health Research Ethics Committee (NHREC) registration number REC-050411-032.

We wish you the best as you conduct your research.

If you have any questions or need further help, please contact the REC office at 0218839027.

Included Documents:

- letter of response
- Desc form
- Revised observation schedule
- Revised REC Application
- revised consent forms
- Permission letter
- Research proposal
- Revised Research proposal
- Consent form 2
- REC application
- Consent form 1
- Permission letter

Sincerely,

Susara Oberholzer
REC Coordinator

Research Ethics Committee: Human Research (Humanities)

Investigator Responsibilities

Protection of Human Research Participants

Some of the general responsibilities investigators have when conducting research involving human participants are listed below:

1. Conducting the Research. You are responsible for making sure that the research is conducted according to the REC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research. You must also ensure that the research is conducted within the standards of your field of research.

2. Participant Enrollment. You may not recruit or enroll participants prior to the REC approval date or after the expiration date of REC approval. All recruitment materials for any form of media must be approved by the REC prior to their use. If you need to recruit more participants than was noted in your REC approval letter, you must submit an amendment requesting an increase in the number of participants.

3. Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the REC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least five (5) years.

4. Continuing Review. The REC must review and approve all REC-approved research proposals at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period**. Prior to the date on which the REC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in REC approval does not occur**. If REC approval of your research lapses, you must stop new participant enrollment, and contact the REC office immediately.

5. Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the REC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written REC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

6. Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research related injuries, occurring at this institution or at other performance sites must be reported to Malene Fouch within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the REC's requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Research Ethics Committee Standard Operating Procedures. All reportable events should be submitted to the REC using the Serious Adverse Event Report Form.

7. Research Record Keeping. You must keep the following research related records, at a minimum, in a secure location for a minimum of five years: the REC approved research proposal and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the REC

8. Provision of Counselling or emergency support. When a dedicated counsellor or psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

9. Final reports. When you have completed (no further participant enrollment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the REC.

10. On-Site Evaluations, Inspections, or Audits. If you are notified that your research will be reviewed or audited by the sponsor or any other external agency or any internal group, you must inform the REC immediately of the impending audit/evaluation.

Appendix B

APPROVAL NOTICE: WESTERN CAPE DEPARTMENT OF HEALTH

**STRATEGY & HEALTH SUPPORT**

Health.Research@westerncape.gov.za
tel: +27 21 483 6857; fax: +27 21 483 9895
5th Floor, Norton Rose House, 8 Riebeeck Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: WC_2016RP15_290 (2014RP063)
ENQUIRIES: Ms Charlene Roderick

Stellenbosch University
Francie van Zijl Drive
Tygerberg
7505

For attention: **Ms Janina Theron**

Re: **Listening in HIV Counselling and Testing – hearer signals in multilingual medical consultation**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact **S Neethling** on **023 348 8102** to assist you with any further enquiries in accessing the following sites:

██████████ Clinic


██████████ Clinic

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the *estimated completion date* which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
4. The reference number above should be quoted in all future correspondence.

Yours sincerely


DR A HAWKRIDGE
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 6/7/2016
CC L PHILLIPS



DIRECTOR: CAPE WINELANDS

Note for Appendix C:

Although approval was given via email in September 2014, following correspondence requesting written confirmation in the form of this document was left unanswered. In reaction to this verbal agreement of approval, both clinics and staff involved also granted permission to do the data collection after which appointments were made and data collection was dealt with during the period of approval. The official document of approval was thus provided by the WCDoH *ex post facto* as included here.


Appendix C

DATA COLLECTION PERMISSION: CLINIC A

	Western Cape Government	PHC CLINIC BREEDE VALLEY SUB DISTRICT zsass@pgwc.gov.za tel: +27 23 356 2649/42 fax: +27 23 356 2499 Wilgerstraat, [REDACTED], 6875 www.capegateway.gov.za
		
Aan wie dit mag aangaan		
<p>Hiermee gee ek, Sr [REDACTED] vir Janina Theron, met PhD navorsing, getiteld "Listening in HIV Counselling and Testing – hearer signals in multilingual medical consultation" by die Universiteit van Stellenbosch, toestemming om onder my toesig haar data-insameling by die [REDACTED] kliniek af te handel. Hierdeur sal die student geakkommodeer word by die [REDACTED] kliniek gedurende die tyd wat sy sal nodig hê om 10 – 15 opnames van berader-pasiënt konsultasies te verkry.</p>		
<p>Hierdie bemagtiging geld slegs mits die student klaring en toestemming van die Universiteit van Stellenbosch se etiekomitee sowel as die Wes-Kaapse Departement van Gesondheid gekry het om hierdie studie te loods.</p>		
Vriendelike Groete		
<hr/>		02 Augustus 2013 ([REDACTED] Kliniek)
Haarlem Street, Worcester, 6850 tel: +27 233 488 100		Private Bag X3079, Worcester, 6849 www.capegateway.gov.za

Appendix D

DATA COLLECTION PERMISSION: CLINIC B

 Western Cape Government Health	Distriks Hospitaal
<hr/>	
Date: 29/07/2013	
<p>To whom it may concern:</p> <p>With this letter I would like to state my willingness to help Me Janina Theron, PhD student from Stellenbosch University, with her thesis titled “Listening in HIV Councillng and Testing – Hearing signals in multilingual medical consultation.”</p> <p>She will record 10 to 15 consultations between councillor and patient (with their consent).</p>	
<p>Family Physician and Clinical Operations Officer Witzenberg Subdistrict Cape Winelands East District</p>	
<p>HOSPITAL, PRIVATE BAG X54,</p>	

Appendix E(a)

DEELNEMERTOESTEMMINGSVORM



UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvenoot • your knowledge partner

UNIVERSITEIT STELLENBOSCH

TOESTEMMINGSVORM TOT DEELNAME AAN NAVORSING

Titel van navorsingsprojek: **Listening in HIV Counselling and Testing – hearer signals in multilingual medical consultation**

U word genooi om deel te neem aan 'n navorsingsprojek uitgevoer deur Mej. Janina Theron (BA, MPhil) van die Departement Algemene Taalwetenskap aan die Universiteit van Stellenbosch. Die resultate van hierdie studie sal in haar PhD-tesis en gepubliseerde artikels verskyn. U is geselekteer as 'n moontlike deelnemer aan hierdie studie omdat u 'n besoeker is wat moontlik behandel sal word by die Ceres / DeDoorns dagkliniek vir 'n mediese konsultasie waar verskillende Suid-Afrikaanse tale gebruik word.

1. DOEL VAN DIE STUDIE

Die doel van hierdie studie is om ondersoek in te stel na die maniere waarop voorsieners van gesondheidsorg (dokters, verpleegsters en beraders) in verskillende tale kommunikeer om inligting in gesondheidsorg oor te dra. Ek stel belang in die maniere waarop sprekers deel neem aan konsultasies waar die hoofdoel die oordrag van inligting oor gesondheidsorg is. Ek wil waarneem hoe die luisteraar aandui dat hy/sy die spreker volg, of nie.

2. PROSEDURES

Indien u instem om aan hierdie studie deel te neem, vra ons die volgende:

- i) 'n Paar minute van u tyd waarin ons die navorsing aan u verduidelik;
- ii) U toestemming om u gesprek met die dokter of berader met 'n videokamera op te neem sodat die opname na die tyd gebruik kan word om meer sorgvuldig te kyk na hoe die konsultasie uitgevoer is (watter tale gebruik is, watter maniere van begrip getoon is, watter vrae gevra is, ens.).

Let wel dat die konsultasies vir navorsingsdoeleindes alleen opgeneem sal word, en dat dit slegs deur die navorser gebruik sal word, sonder enige moontlikheid van herkenning van die sprekers of luisteraars deur ander mense.

3. POTENSIËLE RISIKO'S EN ONGEMAK

Daar is geen voorsienbare risiko's nie. U mag moontlik ongemak ervaar en kan enige tyd vra om die opname te stop, sou u wou.

4. POTENSIËLE VOORDELE VIR DEELNEMERS EN/OF DIE GEMEENSKAP

U sal nie direk bevoordeel word deur u deelname nie. Indien ons inligting bekom wat toekomstige pasiënte en voorsieners van gesondheidsorg in die kliniek kan help, sal die kennis aan hulle oorgedra word.

5. VERGOEDING VIR DEELNAME

U sal nie vergoed word vir u deelname aan die studie nie.

6. VERTROULIKHEID

Enige inligting wat bekom word in verband met hierdie studie wat met u geïdentifiseer kan word, sal vertroulik bly en nie aan enige buitestanders openbaar word nie. Ons sal die opnames in 'n rekenaar hou waarvan die wagwoord slegs aan die navorser en studieleiers bekend sal wees. Verder sal u naam met die opskryf van die navorsing verander word sodat u nie persoonlik herkenbaar sal wees nie.

U het die reg om na die opnames te luister. U het ook die reg om u opnames na die tyd aan die studie te onttrek.

Wanneer die resultate bekend gemaak en gepubliseer sal word, sal u identiteit steeds beskerm word deurdat geen persoonlike inligting te enige tyd gebruik sal word nie.

7. DEELNAME EN ONTTREKKING

U het die keuse om deel te neem aan hierdie studie of nie. Indien u vrywilliglik instem om deel van die studie te wees, kan u te enige tyd, sonder enige gevolge aan die studie onttrek.

8. IDENTIFIKASIE VAN NAVORSERS

Indien u enige vrae of besorgdheid oor die navorsing het, maak gerus kontak.

Naam van navorser: Mej Janina Theron

Telefoon: 0716064481

E-posadres: janinat@sun.ac.za

Studieleier: Prof. Christine Anthonissen

Faksnommer: 021 808 2009

E-posadres: ca5@sun.ac.za

9. REGTE VAN NAVORSINGSDEELNEMERS

U mag u toestemming te enige tyd onttrek en dus u deelname sonder straf staak. U doen nie afstand van enige wetlike eise as gevolg van u deelname aan hierdie studie nie.

Indien u enige vrae rondom u regte as 'n navorsingdeelnemer het, mag u die Afdeling van Navorsingsontwikkeling by die Universiteit van Stellenbosch skakel:

Ms Maléne Fouché

Tel. 021 808 4622

E-pos: mfouche@sun.ac.za

HANDTEKENING VAN DEELNEMER OF REGSVERTEENWOORDIGER

Die bogenoemde inligting is aan my verduidelik deur Mej. Janina Theron in Afrikaans en ek verstaan hierdie taal. Ek was die geleentheid gegun om vrae te vra en hierdie vrae was tot my bevrediging beantwoord.

Hiermee stem ek vrywilliglik in om deel te naam aan hierdie studie. 'n Afskrif van hierdie vorm is aan my gegee.

Naam van deelnemer

Handtekening van deelnemer

Datum**HANDTEKENING VAN NAVORSER**

Ek verklaar dat ek die inligting in hierdie dokument aan _____ [*naam van deelnemer*] verduidelik het. [Hy/sy] is aangemoedig om te enige tyd enige vrae aan my te vra. Die gesprek is in Afrikaans / Engels gevoer en daar is nie van 'n tolk gebruik gemaak nie.

Handtekening van navorser

Datum

Appendix E(b)

PARTICIPANT CONSENT FORM



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jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH

Working Title: Listening in HIV Counselling and Testing – hearer signals in multilingual medical consultation

You are asked to take part in research conducted by Ms Janina Theron (BA, MPhil), from the Department of General Linguistics at Stellenbosch University. The results of this study will be reported in a PhD thesis and published research articles. You were selected as a possible participant in this study because you are a visitor who may be treated at the Ceres / DeDoorns day care clinic who is here for medical consultation where different South African languages are used.

1. PURPOSE OF THE STUDY

The purpose of this study is to investigate how health care providers (doctors, nurses and counsellors) with different first languages, communicate in providing health care information. I am interested in the ways in which speakers take part in consultations where the main aim is to give information about health care. I want to see how the listener shows that s/he is following the speaker.

2. PROCEDURES

If you volunteer to participate in this study, we ask for the following:

- i) A few minutes of your time in which we explain the research to you;
- ii) Your permission to video record your conversation with the doctor or counsellor so that the recording can be used afterwards to look more carefully at how the consultation was done (which languages used, which ways of showing understanding, which kinds of questions are asked, etc.)

Note that the consultation will be recorded for the purposes of the research only, and will be used by the researcher only without any possibility of others recognising speakers and listeners.

3. POTENTIAL RISKS AND DISCOMFORTS

There are no foreseeable risks. You might experience some discomfort and you can request to stop the recording at any time, should you wish to do so.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

You will not benefit directly from your participation. If we learn things that can help future patients and people working with patients in the clinic, such knowledge will be passed on to them.

5. PAYMENT FOR PARTICIPATION

You will not get payment for participation.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will not be disclosed to any others. We will keep recordings in a computer that has a password known only by the researcher and the supervisors. Also, in writing up the research your name will be changed, so that you are not personally identifiable.

You have the right to listen to the recordings. You also have the right afterwards to withdraw the recordings from the study.

When the results are reported and published, your identity will continue to be protected in that no personal information will be used at any stage afterwards.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact me, the researcher. My details, and the details of my supervisor, are as follows:

Researcher's Name: Ms Janina Theron

Telephone 0716064481

Email address: janinat@sun.ac.za

Supervisor: Prof. Christine Anthonissen

Fax Code: 021 808 2009

Email address: ca5@sun.ac.za

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study.

If you have questions regarding your rights as a research subject, you may contact the Division for Research Development at Stellenbosch University:

Ms Maléne Fouché

tel. 021 808 4622

e-mail: mfouche@sun.ac.za

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

The information above was explained to me by Ms Janina Theron in English and I understand this language. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

Name of Participant

Signature of Participant

Date**SIGNATURE OF INVESTIGATOR**

I declare that I explained the information given in this document to _____ [*name of the participant*]. [*He/she*] was encouraged and given time to ask me any questions. This conversation was conducted in Afrikaans / English and no interpreter was used.

Signature of Investigator

Date

Appendix F

PARTICIPANT METADATA FORM

Languages in Medical Discourses - Participants for recording

Metadata:

Date of conversation: Time:

Name:

Contact tel nr:

Age:

Gender:

Place of birth:

Place of schooling:

Means of getting to the clinic:

Current home town/place:

Which language(s) does the participant know:

Home Language:

Afrikaans	English	isiXhosa	Sesotho			

Last school year: date Grade completed:

Additional qualifications:

Employment:

Trained as:

Worked as:

Current employment:

How long has the participant been visiting this clinic (for any kind of medical care)

.....